[Community Safe Harbor]
MEMBER BENEFIT AGREEMENT

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Maine Community Health Options ("MCHO"). If you have a Medicare supplement policy or major medical policy, this coverage may be more than you need. For information, call the Bureau of Insurance at 1-800-300-5000.

Renewal

Unless your coverage under the Plan from MCHO terminates, when you pay your Premium charges, your coverage renews for the period covered by the Premium. Periodically, your Premium may change, subject to approval by the Bureau of Insurance. When a change in your Premium occurs, you will receive written notification from us, advising you of the new Premium and the effective date of the change. We will give you at least 60 days' notice of a Premium increase. The change in your Premium will appear in your next bill after the effective date of the change.

10 Day Agreement Review

This *Member Benefit Agreement*, the *Benefits and Prescription Drugs Schedule*, any Riders, and the [*Single Streamlined Application*] (together, the "Agreement") make up the Member's contract and complete coverage with MCHO for Benefits under the Plan. This Agreement replaces any previous health coverage agreement with MCHO you may have received.

If you decide not to accept this Agreement, return it within 10 days after its delivery date to:

[Maine Community Health Options
Attn: Member Services
P.O. Box 1121
Lewiston, ME 04243]

Please include a signed written request to cancel the Agreement. We will then refund any Premium charges you have paid us for the Agreement.

No Pediatric Dental Benefits

This Agreement and the Plan do not provide Benefits for pediatric dental services. Benefits for pediatric dental services must be purchased from another source that offers such benefits.

Contacting MCHO

You may contact MCHO Member Services at:

[Maine Community Health Options

Attn: Member Services
P.O. Box 1121
Lewiston, ME 04243]

Toll-free number: [1-855-624-6463 (TTY/TDD: 711)]
Internet: [www.maineoptions.org]

Non-English speaking Members may call MCHO Member Services at [1-855-624-6463 (TTY/TDD: 711)] to have their questions answered. MCHO offers free language interpretation services for people who do not speak English or who have limited English speaking abilities.

Deaf and hard-of-hearing Members may communicate with MCHO Member Services by calling [711]. A specially trained operator will help you communicate with MCHO Member Services.

Table of Contents

1. INTRODUCTION

A. Introduction to the Agreement

Thank you for choosing MCHO's [Name of Plan] (the "Plan"). This Agreement is the legal document that defines the relationship between Members and MCHO. It describes the Benefits, limitations, conditions, exclusions, and other important information relevant to Members enrolled in the Plan. **Read this Agreement very carefully.**

MCHO agrees to cover and arrange for health care services to enrolled Members in accordance with this Agreement. By being an enrolled Member under the Plan, you agree to all the terms of this Agreement.

For specific Benefit details, including any Member Out-of-Pocket Costs, please refer to the *Benefits and Prescription Drugs Schedule* for the Plan.

Under the Plan, a Member's health care is mainly provided or arranged through MCHO's network of Primary Care Providers ("PCP"), Specialist Providers, and other Providers. The Plan provides Benefits for the health care services described in this Agreement, the *Benefits and Prescription Drugs Schedule*.

MCHO also provides Members with a *Member Handbook*. The *Member Handbook* is not part of this Agreement. Rather, the *Member Handbook* provides Members with helpful information and answers common questions about MCHO's services.

B. About Maine Community Health Options

MCHO is a Consumer Operated and Oriented Plan ("CO-OP"). The U.S. Centers for Medicare and Medicaid Services has established guidelines for CO-OPs. MCHO is a private, nonprofit entity governed by a Board of Directors made up mostly of Members. This representative Board gives Members like you a strong voice in the management and development of MCHO.

Our Mission:
To partner with Maine people, businesses, and health professionals to provide affordable, high quality benefits that promote health and wellbeing.

Our Values:
Maine Community Health Options believes that:

- *Every person is entitled to courtesy and respect.*
- *A trustworthy organization demonstrates honesty, integrity, independence, and consistency in policy and action.*

- *Discipline, focus, courage, and humility enable us to be open to learning from the challenges that confront us.*
- *It is important to embrace change and see positive potential in disruptive innovation.*
- *Spontaneity, balance, thoughtfulness, and curiosity are essential.*

Our Vision:
To be a leader in transforming the health of Maine people and positively affecting the Maine economy.

C. How this Agreement Works

1. Generally

This document explains:

- Which health care services are Covered Services;
- What is excluded from coverage under the Agreement;
- How to obtain Covered Services and how to obtain Prior Approval;
- Your Out-of-Pocket Costs, that is, costs you must pay (details are in the *Benefits and Prescription Drugs Schedule*);
- Prescription drug benefits (details are in the *Benefits and Prescription Drugs Schedule*); and
- Other information about your relationship with MCHO.

2. Defined Words

At the end of this Agreement, you will find a Glossary of defined words used in this Agreement. You will also find elsewhere in this Agreement other defined words. These defined words begin with capital letters. It is important that you understand what these defined words mean.

When this Agreement uses the words "we," "us," and "our," this means MCHO and its designated affiliates. When this Agreement uses the words "you" and "your," this means the Subscriber and all Members and Dependents.

Unless otherwise clearly noted, lengths of time expressed in terms of days in this Agreement shall mean calendar days.

3. *Benefits and Prescription Drugs Schedule*

The *Benefits and Prescription Drugs Schedule* lists your expected Out-of-Pocket Cost for Benefits covered under the Plan and describes your prescription drug Benefits under the Plan.

4. Plan Providers and the Provider Directory

The Provider Directory lists the PCPs, Specialists, Hospitals, and other Plan Providers who have contracts with MCHO to provide Covered Services to our Members. The regularly updated Provider Directory is available online at [www.maineoptions.org]. If you do not have online access, you may obtain a printed copy by calling Member Services. Members are encouraged to use Plan Providers. Your Out-of-Pocket Costs are typically lower when you receive Covered Services from a Plan Provider rather than a Non-Plan Provider. MCHO Member Services can answer questions about our Plan Providers.

Plan Providers have contracts with MCHO that can be terminated from time to time, even without notice. If your Plan Provider leaves our network for any reason, we will try to give you at least 60 days' notice. In any case, we will give you as much notice as we can. To find a new Plan Provider, you may review the Provider Directory or contact Member Services.

In some cases, we may continue to cover the care you receive from your leaving Plan Provider with the same Out-of-Pocket Costs to allow for a smooth transition to a new Plan Provider. If you are undergoing a course of treatment with a Plan Provider who leaves MCHO's network, you may have the same Out-of-Pocket Costs with that leaving Plan Provider for at least 90 days from when we notify you that your Plan Provider is leaving. If you are a pregnant Member in the 2nd or 3rd trimester and we notify you that your Plan Provider is leaving, you may have the same Out-of-Pocket Costs, related to that pregnancy, with that leaving Plan Provider through postpartum care.

In the event that you are not able to obtain services from a Plan Provider in your area, you or your Provider should call MCHO at [1-855-624-6463 (TTY/TDD: 711)] to seek assistance in finding a Plan Provider.

D. Member Rights and Responsibilities

As a Member of the Plan, you have the following rights:

- You have a right to detailed information about your Plan. This may include information about Benefits and services that are covered under or excluded from the Plan, and all requirements that must be followed for Prior Approval.
- You have a right to information about your Out-of-Pocket Costs, and an explanation of your financial responsibility for services provided to you.
- You have a right to be treated in a manner that respects your privacy and dignity. We will follow applicable laws and our policies when we handle your information.
- You have a right to participate with your Providers in making decisions about your health care.
- You have a right to voice complaints or file Appeals with the Plan, and to contact regulatory bodies about the Plan.
- You have a right to make recommendations regarding the Plan's Member Rights and Responsibilities policies.

- You have a right to receive appropriate assistance from MCHO in a prompt, courteous, and responsible manner.
- You have a right to be promptly informed of termination or changes in Benefits, services, or Plan Providers.
- You have a right to receive an explanation of why a Benefit is denied; the opportunity to Appeal the denial decision; the right to a second level of Appeal with the Plan; and the right to contact the Maine Bureau of Insurance.
- You have a right to adequate access to Providers near your home or work within the Plan's service area.
- You have a right to receive detailed information about which services require Prior Approval and how to request Prior Approval.
- You have a right to have access to a current list of Plan Providers in the Plan's network.
- You have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage.
- You have a right to have someone help you follow your responsibilities and exercise your rights under the Plan.

As a Member of the Plan, you have the following responsibilities:

- You have a responsibility to provide honest and complete information to the Plan and to your Providers.
- You have a responsibility to read and understand the information that you receive about your Plan.
- You have a responsibility to know how to properly access coverage and utilize your Plan.
- You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your Providers.
- You have a responsibility to follow plans and instructions for care that you have agreed to with your Provider.
- You have a responsibility to present your Member identification card before you receive care.
- You have a responsibility to pay your applicable Deductible, Coinsurance and Copayment amounts.
- You have a responsibility to express your opinions, concerns or complaints in a constructive way to the Plan or to your Provider.
- You have a responsibility to timely inform the Plan of any changes in family size, address, phone number, or eligibility status.
- You have a responsibility to make Premium payments on time.
- You have a responsibility to notify the Plan if you have any other insurance coverage.

2. HOW YOUR PLAN WORKS

A. Getting Care from Your Primary Care Provider ("PCP")

1. Choosing Your PCP

When you enroll, you have the opportunity to identify PCPs for yourself and each of your Dependents. If you do not choose a PCP when you first begin coverage

with MCHO, or if the PCP you select is not available, we will assign a PCP for you. You have the option to change your PCP at any time. To change your PCP, please call Member Services. If your PCP stops being a Plan Provider, we will try to give you 60 days' advance notice. In any case, we will give you as much notice as we can. You will then need to select a new PCP who is available or we will assign one for you.

It is important for you to get to know your PCP soon after your coverage first begins or whenever you choose or are assigned a new PCP. You should have your medical records sent to your new PCP.

A Referral from your PCP is not required for visits to specialty Providers, but we encourage you to notify your PCP so that your PCP can help coordinate your care.

Preventive services (please see section 4.B.60) are covered with no Out-of-Pocket Cost to you when provided by an in-network Provider. In addition, you will have no Out-of-Pocket Costs for the first three non-preventive services office visits to your PCP each Calendar Year.

2. Obtaining Care from Your PCP

When you need care, we recommend that you first contact your PCP. Your PCP can help coordinate the care you need. In the event of a Medical Emergency, you should obtain needed care immediately. Your PCP's office can tell you how they cover patient needs outside of business hours.

B. Going to the Hospital or a Specialist

This Plan covers Hospital and Specialist services. The Plan does not require Referrals, but in some cases, Prior Approval by MCHO is required. Please refer to section 2.E for more information.

C. If You Have a Medical Emergency

If you need Medical Emergency services, you should go immediately to the nearest emergency department or call 9-1-1 or another local emergency number. You do not need Prior Approval for Medical Emergency services.

Medical Emergencies include, but are not limited to:

- Heart attack;
- Stroke;
- Severe trauma;
- Shock;
- Loss of consciousness;
- Seizures; or

- Convulsions.

If you are hospitalized, you or your Designee must call your PCP and MCHO within 48 hours after receiving Medical Emergency services. If you or your Designee cannot call within 48 hours, then we should be called as soon as possible. If your Medical Emergency services Provider tells your PCP and MCHO that you have been hospitalized, you do not need to call your PCP and MCHO. Your PCP will arrange for any follow-up care you may need.

Your emergency department Out-of-Pocket Costs are listed on the *Benefits and Prescription Drugs Schedule*. If you are admitted to the Hospital from the emergency department, your Out-of-Pocket Costs for the emergency department visit as outlined in the *Benefits and Prescription Drugs Schedule* will be waived.

D. MCHO *Medical Policy*

MCHO has a *Medical Policy* to help MCHO determine if services are Medically Necessary. We will utilize our *Medical Policy* only for services that are Covered Services. MCHO periodically reviews the value and effectiveness of new medical technologies and treatments. Those technologies and treatments that are deemed appropriate will be included as part of our benefit structure.

E. Prior Approval

1. Introduction

Some Covered Services require MCHO's Prior Approval before we will pay Benefits. The Prior Approval program helps us ensure that:

a. The services you receive are Medically Necessary;
b. You receive the appropriate level of care in the appropriate setting;
c. Information is shared with your Providers so that your care can be coordinated; and
d. We pay the correct amount of Benefits.

For services requiring Prior Approval, MCHO makes the initial coverage determinations within two working days after obtaining all necessary information. If MCHO does not receive enough information to make a Prior Approval decision, MCHO will notify the Provider within two business days after the Prior Approval request that more information is needed. MCHO will inform you and your Provider within two business days after the Prior Approval request is made if MCHO needs to consult someone outside of MCHO to make a decision.

For Medical Necessity determinations involving ongoing care, MCHO will provide notice of the coverage determination within one working day after obtaining all necessary information. Ongoing care will be continued without

liability to the Member until the Member is notified of the coverage determination.

We will notify you and your Provider of our Prior Approval decisions. Our Prior Approval decisions will discuss whether the requested service is Medically Necessary and is a Covered Service. All denial of coverage determinations based on Medical Necessity are initially communicated verbally to the Provider(s), then followed up in writing to the Member and Provider(s). The written notification cites the reason(s) why the decision was made and includes information about the Appeals process and the right to request in writing copies of any clinical criteria applied in a denial of coverage decision. Additionally, Members will receive written notification of any denial of coverage that is based on non-covered Benefits or Benefit limits that have been reached. For more information on the process for appealing Adverse Utilization Determinations and Adverse Health Care Treatment Decisions, please see section 9, Appeals and Complaints.

If we grant Prior Approval for a Covered Service that is based on information given to us that is fraudulent or materially incorrect, we may retroactively deny Prior Approval for that Covered Service.

Sometimes, your Prior Approval request will be medically reviewed by a Physician (or a qualified clinician for mental health or substance abuse services). As described above, we will tell you and your Provider our decision. We will also tell you and your Provider what criteria we used to conduct the medical review.

We do not pay or give incentives to our employees or contracted Providers to improperly deny or withhold Benefits. MCHO staff involved in Prior Approval decisions must also sign a conflict of interest statement each year.

2. Services Needing Prior Approval

Some services require Prior Approval before Benefits will be provided by the Plan. If you have any questions or need assistance to determine which services require Prior Approval, please visit [www.maineoptions.org] or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

3. Seeking Prior Approval

If you use a Plan Provider, he or she is responsible for obtaining Prior Approval for you. If you use a Non-Plan Provider or your services are ordered by a Non-Plan Provider, you (or your Designee) are responsible for obtaining Prior Approval for any services requiring Prior Approval. To seek Prior Approval, please contact MCHO at [1-855-624-6463 (TTY/TDD: 711)].

Services for Medical Emergencies do not need Prior Approval. However, in the event of an admission due to a Medical Emergency, you (or Designee) must contact MCHO within 48 hours after you are admitted or as soon as reasonably possible. However, if your Medical Emergency services Provider tells your PCP and MCHO that you have been hospitalized, you do not need to call your PCP and MCHO.

4. Prior Approval and your Benefits

If Prior Approval is granted for a service, Benefits will be paid as described in the *Benefits and Prescription Drugs Schedule* (unless there is a reason to deny Benefits).

If you fail to obtain Prior Approval for a service needing Prior Approval, you will not receive Benefits for that service and you may be responsible for the full cost of the service. However, if you receive a service where you did not obtain Prior Approval, and MCHO later determines that the service would have been approved if Prior Approval had been appropriately sought, coverage will be provided as stated in the *Benefits and Prescription Drugs Schedule* minus the penalty. The penalty will not exceed $500. The penalty will not apply toward your Deductible or Out-of-Pocket Cost limits. You will not be penalized if you fail to notify MCHO of a hospitalization for treatment of a Medical Emergency.

Below is a list of services that require notification or Prior Approval. For the current list of these services, visit [www.maineoptions.org] or contact Member Services.

Services that require notification (see sections 6.B and 6.C for details)

- All Inpatient surgical or medical admissions
- All Inpatient behavioral health admissions
- Observation status (24 hours or less)

Services that require Prior Approval

- 48-hour observation stays
- Allergy testing for children less than 5 years old
- Assistant surgeons for Outpatient/Ambulatory Surgery
- Bariatric Surgery
- Chiropractic care for the 9th visit and beyond
- Durable Medical Equipment (DME) purchase over $300/line item and all DME rentals
- Experimental/Investigational services
- General anesthesia for dental services (excluding individuals classified as vulnerable rendered at a Hospital)
- Genetic Testing

- Home environmental assessment
- Home sleep studies
- Hospice exceeding 8 hours a day
- In-Home Biometric Monitoring
- Injectable and infusion drugs over $300/dose
- Inpatient rehabilitation
- Medically Necessary amino acid based elemental infant formula
- Mental Health and Substance Abuse for the 9th visit and beyond
- Non-Emergency MRI's, MRA's, and CT scans
- Non-emergency Outpatient/ambulatory procedures including surgical procedures (excludes procedures performed in office)
- Non-emergency procedures requiring Inpatient admission
- Non-emergency use of ambulance for medical transportation
- Oral surgery procedures
- Outpatient occupational, physical, and speech therapy (including home therapy) for the 9th visit and beyond.
- Pain management invasive procedures (excludes initial office visit)
- PET Scans
- Plastic Surgery
- Podiatry care (excludes office visits)
- Replacement or repair of purchased DME
- Respite care
- Second Opinions to a Non-Plan Provider
- Services performed in Sleep Labs (including sleep studies and pneumograms)
- Skilled Nursing Facility
- Transfer from Hospital to Hospital for NICU
- Transplants

3. ENROLLMENT AND ELIGIBILITY

A. Enrollment

You can enroll under the Plan during an annual Open Enrollment Period or a Special Enrollment Period. [You must begin the enrollment process through Maine's Health Insurance Marketplace.]

1. Open Enrollment

During the annual Open Enrollment Period, you can review your existing MCHO plan and determine if you need to make changes. Open Enrollment is also an opportunity for non-MCHO Members to purchase an MCHO plan.

Starting in 2014, the annual Open Enrollment Period will run from October 15 to December 7. All coverage purchased during this period will be effective January 1 of the following year. Notice about this open enrollment period will occur no earlier than September 1 and no later than September 30.

If you are new to MCHO, you will have 10 days from the date of your first enrollment to end your agreement. Your premium will be refunded if you cancel during this period. See the first page of your Agreement or contact Member Services to learn more about this "free look" period.

2. Special Enrollment

During the year, if you have certain qualifying life-changing events, you and your Dependents can enroll for coverage under the Plan through "Special Enrollment." Special qualifying events, such as birth or adoption of a child, marriage, divorce, loss of other insurance coverage, or changes in eligibility for other public service programs, will trigger Special Enrollment. For a full list of these qualifying events, visit [www.maineoptions.org] or contact Member Services.

To take advantage of Special Enrollment, you must submit the completed [*Single Streamlined Application*] for new Dependent coverage.

If you become a Member or add new Dependents through Special Enrollment, the effective date of coverage depends on the type and date of event, as well as when MCHO receives a completed [*Single Streamlined Application*] and premium payment.

B. Member and Dependent Eligibility

[The Plan is being offered through Maine's Health Insurance Marketplace. You will need to apply for coverage under the Plan through the Health Insurance Marketplace's process. After you apply, you may learn that you qualify for financial assistance to pay your Premiums.]

1. Member Eligibility

To be a Member under this Plan, you must meet one or both of the following conditions: (1) you must be under the age of 30 before the Plan year begins, or (2) have received a certification from the Health Insurance Marketplace that you are exempt from the individual mandate because you do not have an affordable coverage option or because you qualify for a hardship exemption.

2. Dependent Eligibility

In addition to meeting one or both of the conditions described in section 3.B.1 above, a Dependent must meet one of the requirements for coverage listed below:

a. The Subscriber's legal spouse or legal domestic partner (a legal domestic partnership exists when it meets all the criteria provided in the Maine Insurance Code for domestic partnerships).

b. A child, who is under age 26, of the Subscriber or the Subscriber's spouse or domestic partner, including newborn children, biological children, adopted children or children Placed for Adoption, stepchildren, and children for whom the Subscriber or the Subscriber's spouse/domestic partner is a legal guardian.

c. An unmarried child of the Subscriber or spouse/domestic partner who is age 26 or older, has a mental or physical disability that began before the child turned 26 years old, and is dependent on the Subscriber.

d. A child who is eligible as a Dependent because of a Qualified Medical Support Order ("QMSO") or other court or administrative order requiring medical coverage for a child of a Subscriber or spouse/domestic partner of the Subscriber. Such child will be eligible for medical coverage as stated in the QMSO or other court or administrative order.

A QMSO is a judgment, decree, or order issued by a court or administrative agency that meets certain federal law requirements.

3. Other Eligibility

MCHO will permit individuals to enroll for coverage under the Plan as otherwise required by law.

MCHO may require the Subscriber to submit reasonable evidence of eligibility for Dependent coverage from time to time. Please contact MCHO if you have questions about what evidence MCHO may require.

C. Effective Dates

Your coverage will begin under the Plan on the effective date of your Agreement. You will not receive Benefits for any services, supplies, or equipment provided to you or received by you before your individual effective date of coverage under this Agreement. If you have an Inpatient Stay before and on your effective date, your coverage will begin on the effective date of this Agreement. For an Inpatient Stay, services, supplies, or equipment provided before your effective date are not covered.

1. New Dependents

New Dependents may be added by paying the applicable Premium and submitting a completed enrollment form for:

a. Marriage or beginning of a legal domestic partnership (and the spouse's/domestic partner's child(ren), if applicable).

Coverage is effective immediately on the date of marriage or legal domestic partnership or if other coverage is in force the effective date will be when the other coverage ends. A [*Single Streamlined Application*] is required within [60] days from the date of marriage or legal domestic partnership;

b. Birth.

A newborn is automatically covered for [60] days from the moment of birth unless the Subscriber notifies us that the newborn will not be covered under this Agreement. For continuous coverage beyond [60] days from birth, you must submit a completed [*Single Streamlined Application*] to us within this [60]-day period;

c. Adoption or Placement for Adoption.

An adopted child or child Placed for Adoption is automatically covered for [60] days from the date of adoption or Placement for Adoption unless the Subscriber notifies us that the adopted child or child Placed for Adoption will not be covered under this Agreement. For continuous coverage beyond [60] days from adoption or Placement for Adoption, you must submit a completed [*Single Streamlined Application*] to us within this [60]-day period;

d. Legal guardianship.

Coverage is effective the date of the court order appointing the guardian if the [*Single Streamlined Application*] is received within [60] days from the date of the court order; or

e. The Subscriber becoming legally responsible for a Dependent's health care coverage.

Coverage is effective the date of the court order or other event creating such legal responsibility if the [*Single Streamlined Application*] is received within [60] days from the date of the court order or event.

Except for the [60] days of automatic coverage after the birth of a child, adoption, or Placement for Adoption under sections 3.C.1.b or 3.C.1.c, to obtain Dependent coverage under this section, you must be able to provide notice and evidence of Dependent status satisfactory to MCHO within [60] days after an event listed in

this section should we require it. We may also request evidence of Dependent status at other times.

If you fail to submit a [*Single Streamlined Application*] during the [60] day period as outlined above, your Dependent can be added during the annual open enrollment period of October 15th through December 7th,or other enrollment period required by law, by submitting a completed [*Single Streamlined Application*].

D. Eligibility Changes

It is the Subscriber's responsibility to promptly inform MCHO of all changes that affect Member and Dependent eligibility.

E. Paying your Membership Premium

When you purchase coverage under the Plan, you will be billed for the Premium on a monthly basis. Payment for the Premium is due the first day of each month for which coverage is provided.

1. Members Not Receiving Tax Credits.

If you do not pay the Premium in full when due, you will have a 31-day grace period to pay the outstanding Premium owed. During the grace period, your coverage will not lapse. If we do not receive the full Premium after the end of the grace period, then we may terminate your coverage under the Plan and this Agreement. Except as otherwise allowed under this Agreement, we will not allow reinstatement after the grace period ends. We reserve the right to take necessary steps to collect outstanding Premiums.

2. Members Receiving Tax Credits.

Members who receive Advanced Payments of Premium Tax Credits (within the Health Insurance Marketplace) and have paid at least one month's Premium, but who subsequently fail to pay the Premium in full, will have a three-month grace period to submit payment in full of outstanding Premium due. MCHO will pay appropriate claims for the first month of the grace period. MCHO may hold claims during the remainder of the grace period.

MCHO will stop holding claims when the full Premium amount owed is paid. If the full amount of the outstanding Premium is not paid by the end of the grace period, MCHO will terminate your coverage under the Plan and this Agreement, and the Member will be responsible for paying for any services received during the 2nd and 3rd months of the grace period.

F. Rebates

To the extent required by law, MCHO may issue a rebate of a portion of your Premium back to you.

G. Parental Notification

You, if you are a parent of a Dependent child, may request that we provide you with:

1. An explanation of the payment or denial of any claim filed on behalf of the Dependent child, except to the extent that the Dependent child has the right to withhold consent and does not affirmatively consent to notifying you;

2. An explanation of any proposed change in the terms of this Agreement; and

3. Reasonable notice that this Agreement may lapse, but only if you have provided MCHO with the address where you may be notified.

You may also provide MCHO with information about a claim relating to your Dependent child so that we may process the claim.

4. COVERED SERVICES

This section contains information on the Covered Services under your Plan. Member Out-of-Pocket Cost information (Copayments, Coinsurance, and Deductibles) and any applicable Benefit limitations that apply to your Plan are listed in your *Benefits and Prescription Drugs Schedule*. Benefits are administered on a Calendar Year basis.

A. Requirements

To be covered and be eligible for Benefits under the Plan, all services and supplies must meet all of the following requirements:

1. Listed as a Covered Service;
2. Be rendered by a Provider within the scope of such Provider's license or certification;
3. Be Medically Necessary;
4. Not be excluded in the "Exclusions from Benefits" section (see section 5);
5. Be received while an active Member of the Plan; and
6. Receive Prior Approval, if applicable. This requirement does not apply to care needed in a Medical Emergency and certain other services (see section 2.E).

Services that are not Covered Services, and services related to non-Covered Services, are not eligible for Benefits.

B. Covered Services

The following services are Covered Services under the Plan:

1. Allergy Testing and Injections. The Plan provides Benefits for allergy testing and injections.

2. Ambulance Service. The Plan provides Benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a Hospital when other transportation would endanger your health.

   The Plan provides Benefits only for ambulance transportation to the nearest Hospital that can provide the required care you need. If you are not taken to a Hospital that is the nearest Hospital that can provide the required care, Benefits will be based on transport to the nearest Hospital that can provide such care.

   Non-Emergency Ambulance Transport
   The Plan provides Benefits for non-emergency ambulance transport between Hospitals or other covered health care facilities or from a covered facility to the Member's home when Medically Necessary. Prior Approval is required.

   Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

3. Ambulatory Surgery Centers. The Plan provides Benefits for certain Covered Services provided by Ambulatory Surgery Centers. Covered Services vary according to the scope of a specific Ambulatory Surgical Center's license.

4. Anesthesia Services. The Plan provides Benefits for anesthesia only if administered while a Covered Service is being provided. An exception is provided under section 4.B.16. The Plan does not provide Benefits for local or topical anesthesia except as part of a regional nerve block.

5. Asthma Education. The Plan provides Benefits for MCHO-approved asthma education programs.

6. Autism Spectrum Disorders Treatment. To the extent required by Maine law, the Plan provides Benefits for the following services for the treatment of Autism Spectrum Disorders for Members who are five years of age or younger:

   a. Any assessments, evaluations, or tests by a licensed Physician or psychologist to diagnose whether a Member has an Autism Spectrum Disorder.
   b. Habilitative or rehabilitative services, including Applied Behavior Analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent

possible. To be covered by the Plan, Applied Behavior Analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.

c. Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor, or clinical social worker.
d. Therapy services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.
e. Prescription drugs.

A licensed Physician or licensed psychologist must determine that a service under this section is Medically Necessary. Such determination must be renewed annually.

7. Blood Transfusions. The Plan provides Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

8. Breast Cancer Treatment. The Plan provides Benefits for breast cancer treatment, including prostheses and the following services:

a. Inpatient care for a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer is covered for a period of time determined to be Medically Necessary by the attending Physician, in consultation with the Member.
b. If the Member elects breast reconstruction following mastectomy surgery, the Plan covers reconstruction in the manner chosen by the Member and the Physician. Coverage includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance.

As required by Maine and federal law, the Inpatient length of stay for a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer will be decided by the attending Provider in consultation with the Member.

9. Breast Reconstruction Surgery. If a Member receives Benefits in connection with a mastectomy and the Member elects breast reconstruction in connection with such mastectomy, to the extent required by federal law, the Plan provides Benefits for, in a manner determined in consultation with the attending Physician and the Member:

a. All stages of reconstruction of the breast on which a mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and physical complications of the mastectomy, including lymphedemas.

10. Breast Reduction Surgery and Symptomatic Varicose Vein Surgery. To the extent required by Maine law, the Plan provides Benefits for breast reduction surgery and symptomatic varicose vein surgery determined to be Medically Necessary by a Physician.

11. Chemotherapy Services. The Plan provides Benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically accepted indications or as required by law. Any FDA treatment investigational new drugs are not covered unless approved by us for medically accepted indications or as required by law.

12. Chiropractic Care. The Plan provides Benefits for Medically Necessary Chiropractic Care. Chiropractic Care is covered as a Specialist visit under the *Benefits and Prescription Drugs Schedule*. Prior Approval is required for the 9th visit and beyond. Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

13. Clinical Trials. To the extent required by Maine law, the Plan provides Benefits for routine patient costs for items and services furnished in connection with participation in an approved clinical trial. The Plan does not provide Benefits for the costs of tests and measurements conducted primarily for the purpose of the clinical trial involved. Coverage includes Medically Necessary services or devices that are not covered by the sponsors of the clinical trial.

The clinical trial must be approved by the federal Department of Health and Human Services, the National Institutes of Health ("NIH"), or an NIH cooperative group or center.

To receive Benefits under this section, the Member's Physician must conclude that the Member meets all of the following requirements:

a. The Member has a life-threatening illness for which no standard treatment is effective;
b. The Member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness; and
c. The Member's participation in the clinical trial offers meaningful potential for significant clinical benefit to the Member.

14. Colorectal Cancer Screenings. The Plan provides Benefits for colorectal cancer screenings for asymptomatic Members who are:

    a. 50 years of age or older; or
    b. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.

    For purposes of this section, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a Provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

15. Contraceptives/Family Planning. The Plan provides Benefits for therapeutic abortion as regulated by Maine law and prescription contraceptives approved by the FDA to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis.

16. Dental Procedures. The Plan provides Benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable. Examples of vulnerable Members include, but are not limited to, the following:

    a. Infants;
    b. Individuals exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
    c. Individuals with acute infection;
    d. Individuals with allergies to local anesthetics;
    e. Individuals who have sustained extensive oral-facial or dental trauma; and
    f. Individuals who are extremely uncooperative, fearful, or anxious.

    The Plan **does not** provide Benefits under this section for any dental procedures or the dentist's fee.

17. Dental Services. The Plan provides Benefits only for the following:

    a. Setting a jaw fracture;
    b. Removing a tumor (but not a root cyst);
    c. Treatment, not to include dental implants, within six months after an Accidental Injury to repair or replace natural teeth or within six months after the effective date of coverage, whichever is later; and

d. Repairing or replacing dental prostheses caused by an Accidental Injury within six months after the injury or within six months after the effective date of coverage, whichever is later.

The Plan does not provide Benefits for services for dental damage that occurs as a result of normal activities of daily living or extraordinary use, such as injury to teeth sustained due to biting or chewing.

18. Diabetes Services and Supplies. The Plan provides Benefits for the following diabetic services and supplies that are determined to be Medically Necessary by the Member's treating Provider:

a. Maine Department of Health and Human Services-approved Outpatient self-management training and educational services used to treat diabetes;
b. Insulin;
c. Insulin pumps;
d. Oral hypoglycemic agents;
e. Glucose monitors;
f. Test strips;
g. Syringes; and
h. Lancets.

19. Diagnostic Services. The Plan provides Benefits for Diagnostic Services, including laboratory tests and x-rays, when they are ordered by a Provider to diagnose specific signs or symptoms of an illness or injury or when the services are part of preventive services covered under this Agreement. Services covered under this section include the services of a Physician with a specialty in radiology.

Certain imaging services require Prior Approval.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

20. Dialysis. The Plan provides Benefits for kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payer for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) the Plan provides Benefits only to the extent payments would exceed what would be payable by Medicare. Your PCP should make all arrangements for dialysis care. Coverage for dialysis in the home includes nondurable medical supplies, drugs, and equipment.

To be covered, dialysis services under this section must be ordered by a Physician.

21. Durable Medical Equipment and Prostheses. The Plan provides Benefits for the rental or purchase of Durable Medical Equipment. Whether you rent or buy the equipment, the Plan provides Benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first. Benefits for replacement or repair of purchased Durable Medical Equipment are subject to Prior Approval.

    Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

    The Plan does not provide Benefits for the repair or replacement of rented equipment.

    Supplies are covered if they are necessary for the proper functioning of Durable Medical Equipment. Supplies for Durable Medical Equipment are not subject to any Durable Medical Equipment maximum applicable to the Plan.

    If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for the disease or injury, Benefits will be based on the least expensive method of treatment, prosthetic device, or Durable Medical Equipment that can meet the Member's needs. Coverage for prosthetic devices is described at section 4.B.62.

22. Early Intervention Services. To the extent required by Maine law, the Plan provides Benefits for Early Intervention Services for children with an identified developmental disability or delay. Benefits are provided for children from birth up to 36 months of age.

    Coverage is only available for services rendered by the following types of Providers:

    a. Occupational therapists;
    b. Physical therapists;
    c. Speech-language pathologists; and
    d. Clinical social workers.

23. Emergency Services. If you have a Medical Emergency, the Plan will provide Benefits for care in a Hospital emergency department. Please remember the following:

    a. If you need follow-up care after you are treated in an emergency department, you should call your PCP.

b. If you are hospitalized, you or your Designee should call us at [1-855-624-6463 (TTY/TDD: 711)] within 48 hours or as soon as you can. However, if your attending emergency department Provider tells the Plan or your PCP within 48 hours that you have been hospitalized, then you do not need to call the Plan.

If you are admitted as an Inpatient to the Hospital from the emergency department, you will not need to pay your Out-of-Pocket Costs for that emergency department visit.

24. Eye Examinations. The Plan provides Benefits for eye examinations received from an eye care Provider in the Provider's office. One routine vision exam, including refraction, to detect vision impairment by a Plan Provider every other Calendar Year is covered.

A diabetic eye exam is covered once annually.

The Plan does not provide Benefits for the fitting or purchase of eyeglasses or contact lenses, except as covered under "Eye Vision Hardware" (section 4.B.25) and "Pediatric Vision" (section 4.B.56).

25. Eye Vision Hardware. The Plan provides certain Benefits for contact lenses or eyeglasses needed for the eye conditions indicated below:

a. Post cataract surgery with an intraocular lens implant (pseudophakes).
b. Post cataract surgery without lens implant (aphakes).
c. Keratonconus.
d. Post retinal detachment surgery.

For details, please contact Member Services at [1-855- 624-6463 (TTY/TDD: 711).

26. Foot Care. The Plan provides Benefits for Medically Necessary podiatry services, including diabetic foot exam and systemic circulatory disease. Routine foot care is not covered.

27. Freestanding Imaging Centers. The Plan provides Benefits for covered Diagnostic Services performed by Freestanding Imaging Centers. All services must be ordered by a Provider.

Certain imaging services require Prior Approval.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

28. Genetic Testing. The Plan provides Benefits for genetic testing or genetic counseling when Medically Necessary and Prior Approval has been obtained.

    Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

29. Hearing Aids. The Plan provides Benefits for wearable Hearing Aids for covered Members up to age 18. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered.

30. Home Health Care Services. The Plan covers home health care services when services are performed and billed by a Home Health Agency. These services are covered if hospitalization or confinement in a residential treatment facility would otherwise have been required. A Home Health Agency must submit a written plan of care to MCHO, and then provide the services approved by MCHO whether or not the patient is homebound.

    The home health care services covered by the Plan include:

    a. Visits by registered nurses and licensed practical nurses;
    b. Physician or nurse practitioner home and office visits;
    c. Visits by a registered physical, speech, occupational, inhalation, and dietary therapist;
    d. Supportive services, including prescription drugs, medical and surgical supplies, and oxygen, but only to the extent that such services would have been covered if you remained in the Hospital; and
    e. Visits by home health aides under the supervision of a registered nurse.

    The Plan covers up to 90 home health care service visits per continuous 12-month period. Please see your *Benefits and Prescription Drugs Schedule* for details.

31. Home Infusion Therapy and Infusion. The Plan provides Benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy Provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.

32. Hospice Care. The Plan provides Benefits for Hospice Care furnished in your home by a Home Health Agency to a Member who is terminally ill and to the Member's family. A Member who is terminally ill means a Member who has a medical prognosis that the Member's life expectancy is 12 months or fewer if the illness runs its normal course.

Prior Approval is required. Hospice Care must be provided according to a written care delivery plan developed by a Hospice Care Provider and the recipient of Hospice Care, which must be submitted to MCHO for Prior Approval.

The agency must then submit a plan of care every 14 days to maintain approval.

The Plan provides Benefits for Hospice Care in an Inpatient setting with Prior Approval. Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

Hospice Care includes, but is not limited to: Physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and Durable Medical Equipment, occupational, physical or speech therapies, home health care services, bereavement services, and volunteer services.

33. Hospice Respite Care. The Plan provides Benefits for up to one 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the Member at home, either a family member or other nonprofessional, to have personal time solely for relaxation.

Before the Member receives respite care at home, a Home Health Agency must submit a plan of care to MCHO for approval. Prior Approval is also required before respite care is provided. Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

34. Hospice Services - Inpatient. The Plan provides Benefits for Inpatient Hospice Care at an acute care Hospital or Skilled Nursing Facility. The same services are covered for Inpatient Hospice Care as are covered under Inpatient Hospital services (section 4.B.40).

35. Inborn Errors of Metabolism. The Plan provides Benefits for metabolic formula for special modified low protein food products. Such food products must be specifically manufactured for patients with diseases caused by Inborn Errors of Metabolism. This Benefit is limited to those Members with diseases caused by Inborn Errors of Metabolism.

36. Independent Laboratories. The Plan provides Benefits for Diagnostic Services ordered by a Provider and performed by independent laboratories.

37. Infant Formulas. To the extent required by Maine law, the Plan provides Benefits for Medically Necessary amino acid-based elemental infant formula for Members two years of age or younger, without regard to the method of delivery of the formula. Coverage will be provided under this section when a Physician Provider

has documented that the amino acid-based elemental infant formula is Medically Necessary, such that:

a. The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and
b. Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated.

In addition, coverage will only be provided to a Member under this section when a Physician Provider has diagnosed, and through medical evaluation has documented, one of the following conditions:

a. Symptomatic allergic colitis or proctitis;
b. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis;
c. A history of anaphylaxis;
d. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
e. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
f. Cystic fibrosis; or
g. Malabsorption of cow milk-based or soy milk-based infant formula.

MCHO may require that a Physician Provider confirm and document at least annually that the formula remains Medically Necessary.

38. Inhalation Therapy. The Plan provides Benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

39. In-Home Biometric Monitoring. The Plan provides Benefits for HIPAA (Health Insurance Portability and Accountability Act)-compliant In-Home Biometric Monitoring related to congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) when Medically Necessary with Prior Approval.

40. Inpatient Hospital Services. The Plan provides Benefits for the following Inpatient Hospital services:

a. Room and board, including general nursing care, special duty nursing, and special diets;
b. Use of intensive care or coronary care unit;
c. Diagnostic Services;
d. Medical, surgical, and central supplies;
e. Treatment services;

f. Hospital ancillary services including but not limited to use of an operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services;
g. Phase I Cardiac Rehabilitation;
h. Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV, or AIDS, unless approved by us for Medically Necessary accepted indications or as required by law. Any FDA treatment investigational new drugs are not covered unless approved by us for Medically Necessary accepted indications or as required by law;
i. Blood and blood derivatives;
j. Prostheses or Orthotic Devices; and
k. Newborn care, including routine well-baby care.

The Plan provides Benefits for a private room if Medically Necessary.

The Plan will stop providing Benefits for an Inpatient Stay at a Hospital after the earliest of:

a. Your discharge as an Inpatient;
b. Reaching any Benefit limits or maximums; or
c. You being told by a Physician, Hospital staff, or MCHO that you are no longer eligible for continued Inpatient Stay at a Hospital.

41. Manipulative Therapy. The Plan provides Benefits for treating acute musculo-skeletal disorders. Manipulative Therapy under this section is covered as a Specialist visit under the *Benefits and Prescription Drugs Schedule*. No Benefits are provided for ancillary treatment such as massage therapy, heat, or electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions.

42. Massage Therapy. The Plan provides Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a Provider. A massage therapist is not a Provider. Massage Therapy under this section is covered as a Specialist visit under the *Benefits and Prescription Drugs Schedule*.

43. Medical Care. The Plan provides Benefits for medical care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits, and pediatric services.

44. Medical Supplies. The Plan provides Benefits for medical supplies furnished by a Provider in the course of delivering Medically Necessary services. This Benefit does not apply to bandages and other disposable items that may be purchased

without a prescription, except for syringes which are Medically Necessary for injecting insulin or a drug prescribed by a Physician.

45. Mental Health and Substance Abuse. The Plan provides Benefits for Inpatient, Outpatient, and Day Treatment Program services for mental health and substance abuse when you receive them from a Provider.

If you receive services from a Community Mental Health Center or Substance Abuse Treatment Facility, services must be:

a. Supervised by a licensed Physician, licensed clinical psychologist, or licensed clinical social worker; and
b. Part of a plan of treatment for furnishing such services established by the appropriate staff member.

The Plan provides Benefits for only the following mental health and substance abuse treatment services:

a. Room and board, including general nursing;
b. Prescription drugs, biologicals, and solutions administered to inpatients;
c. Supplies and use of equipment required for detoxification and rehabilitation;
d. Diagnostic and evaluation services;
e. Intervention and assessment;
f. Facility-based professional and ancillary services;
g. Individual, group, and family counseling;
h. Psychological testing;
i. Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment; and
j. Intervention and assessment.

Once a Member has had eight mental health and/or substance abuse Outpatient office visits combined in a Calendar Year, Prior Approval is required for all further mental health and substance abuse Outpatient office visits for that Calendar Year.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

46. Non-Emergency Care Outside of the United States. The Plan provides Benefits for Inpatient and Outpatient services in a foreign Hospital. You may need to pay the bill when you leave the Hospital. We will reimburse you for Covered Services as outlined within this Agreement. Please refer to sections 2.F and 6 for details pertaining to Prior Approval requirements.

Please call Member Services at [1-855-624-6463 (TTY/TDD: 711)] for instructions on submitting a claim for services provided outside the United States.

47. Nutritional Counseling. The Plan provides Benefits for nutritional counseling when required for a diagnosed medical condition.

48. Obesity. The Plan provides Benefits for treatment of Obesity if you are diagnosed with Obesity for a minimum of five consecutive years. Benefits are limited to bariatric surgery. Prior Approval is required.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

The Plan does not provide Benefits for weight loss medication.

49. Obstetrical Services and Newborn Care. The Plan provides Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. The Plan does not provide Benefits for routine circumcisions. Routine newborn care does not include any services provided after the mother has been discharged from the Hospital. All other Plan provisions such as Deductible and Coinsurance, if applicable, will apply to the newborn if the mother is discharged and the newborn remains in the Hospital.

The Plan will not restrict Benefits for a mother or newborn child for any Hospital length of stay due to childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. This does not prohibit the mother or newborn from being discharged earlier should the attending Provider deem appropriate after consulting with the mother.

50. Off-Label Use of Prescription Drugs for Cancer, HIV, and AIDS. To the extent required by Maine law, the Plan provides Benefits for off-label use of prescription drugs for cancer, HIV, and AIDS.

51. Office Visits. The Plan provides Benefits for office visits to Providers.

52. Organ and Tissue Transplants. As described in this section, the Plan provides Benefits for organ and tissue transplant procedures. You must receive Prior Approval from us before you are admitted for any transplant procedure.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

Covered transplants include: heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel,

parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

The Plan provides Benefits for organ and tissue transplant donors only if (1) the donor is a Member or the donor does not have similar Benefits available from another source, and (2) the recipient is a Member.

53. Orthotic Devices. The Plan provides Benefits for certain Orthotic Devices, such as orthopedic braces, back or surgical corsets, and splints. The Plan does not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

54. Outpatient Services. The Plan provides Benefits for the following Hospital Outpatient and Rural Health Center services:

a. Emergency department services/emergency care;
b. Removal of sutures;
c. Application or removal of a cast;
d. Diagnostic Services;
e. Surgical services;
f. Removal of impacted or unerupted teeth;
g. Endoscopic procedures;
h. Blood administration;
i. Radiation Therapy; and
j. Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for these Benefits.

55. Parenteral and Enteral Therapy. The Plan provides Benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

56. Pediatric Vision. The Plan provides Benefits for Diagnostic Services, eyewear, contact lenses and other vision services (optional lenses and treatments) for Members under the age of 19. No Benefits are provided for the replacement of lenses, frames or contacts. Please see the *Benefits and Prescription Drugs Schedule* for more information.

57. Physical and Occupational Therapy. The Plan provides Benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to limits as described on

your *Benefits and Prescription Drugs Schedule*. Prior Approval is required for the 9th visit and beyond.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless performed by a licensed Provider in conjunction with an active course of treatment.

58. Plastic Surgery. The Plan provides Benefits for certain plastic surgery procedures. Plastic surgery requires Prior Approval and is limited to Medically Necessary surgery needed to treat illness or injury to restore or provide function.

If you have questions about your surgical procedure, please contact your Provider or Member Services.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

59. Prescription Drug Benefits. Your prescription drug Benefit provides coverage for formulary prescription drugs and medical devices purchased for use in a non-Hospital setting. The prescription drug Out-of-Pocket Cost may vary depending on the tier that MCHO assigns to the drug. Please see your *Benefits and Prescription Drugs Schedule* for details.

MCHO reviews and selects drugs for your formulary that will be safe, effective, and affordable. These formulary selections are based on their therapeutic value, side effects, and cost compared to similar medications. MCHO regularly evaluates the formulary to ensure it is up-to-date.

Determination of coverage is made by MCHO. Your formulary is evaluated on an ongoing basis, and could change. MCHO does not send separate notices if a brand-name drug becomes available as a generic drug. The pharmacist usually tells you this information when you fill your next prescription. If you have more questions about the formulary or your Out-of-Pocket Costs, please contact Member Services at [1-855-624-6463 (TTY/TDD: 711)].

You can also view a copy of the current formulary online at [www.maineoptions.org] or you may request a copy of the formulary by calling Member Services at [1-855-624-6463 (TTY/TDD: 711)]. The inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

Specific prescription drugs (or the prescribed quantity of a specific drug) may require Prior Approval. More information about which drugs require Prior Approval is available at [www.maineoptions.org]. On the formulary, medications that require Prior Approval for coverage are marked with "PA" next to the medication.

Prescriptions must be used for their FDA-approved purpose unless Prior Approval for off-label use has been obtained.

We offer other services relating to your prescription drug Benefits. Please see your *Member Handbook* for more details or contact Member Services.

90-Day Program
Our 90-day supply program gives you the convenience of getting up to a 90-day supply of most drugs at participating retail pharmacies. If you get a prescription filled on a regular, recurring basis, talk to your Provider about writing a prescription for a 90-day supply. A list of pharmacies participating in the 90-Day at Retail program can be found at [www.maineoptions.org].

Mail Order
You may also obtain prescription drugs by mail. Please see your *Member Handbook* for more details or contact Member Services.

Continuing Prescriptions from a Prior Carrier
If you have received Prior Approval for a prescription drug from your former insurance carrier, and that prescription drug also requires Prior Approval from MCHO, we want to ensure you can obtain your prescription without interruption while we conduct a review. If your Provider participates in the review and requests that your prior approval be continued, we will extend the approval while we perform a review. Continued approval will be determined based on the decision from our review.

Prescription Refills
The Plan only provides Benefits for prescription refills when you have taken [70%] of the medication from a retail pharmacy or [50%] from mail order, based on the dosage and day supply prescribed by your Provider. The Plan does not provide Benefits for refills exceeding the number specified by the Provider or for refills dispensed after one year from the date of original prescription order.

60. Preventive Care. The Plan provides Benefits for the following preventive services. Preventive care services in this section are those required to be covered by the Plan under federal and state law. Many preventive care services are covered by the Plan with no Out-of-Pocket Costs from the Member as explained in your *Benefits and Prescription Drugs Schedule*. That means the Plan pays 100% of the Maximum Allowable Charge. These services fall under broad categories as shown below:

a. Services with an "A" or "B" rating from the United States Preventive Services Task Force.

b. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention;

c. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may call Member Services at [1-855-624-6463 (TTY/TDD: 711)] for additional information about these services.

Preventive Care screenings are for adults and children that do not have symptoms or prior history of a medical condition. Care required to treat a previously diagnosed medical condition does not fall under Preventive Care. Benefits will be considered under the "Diagnostic Services" section (4.B.19) and subject to the Out-of-Pocket Costs described in the *Benefits and Prescription Drugs Schedule*.

61. Prostate Cancer Screenings. The Plan provides Benefits to male Members aged 50 to 72 for a yearly (1) digital rectal examination, and (2) prostate-specific antigen test. To be covered by the Plan, such services must be recommended by the Member's PCP as Medically Necessary.

62. Prosthetic Devices. The Plan provides Benefits for prosthetic devices to replace, in whole or in part, an arm or a leg. Coverage extends to such prosthetic devices that are determined by a Provider to be the most appropriate and least expensive model that will adequately meet the Member's medical needs. The Plan also covers repair or replacement of such prosthetic devices that is determined to be appropriate by a Provider.

Coverage does not extend to prosthetic devices designed exclusively for athletic purposes.

63. Radiation Therapy. The Plan provides Benefits for Radiation Therapy.

64. Reconstructive Surgeries, Procedures, and Services. The Plan provides Benefits for reconstructive surgeries, procedures, and services, when considered to be Medically Necessary.

Reconstructive surgeries, procedures, and services must meet at least one of the following criteria:

a. Necessary due to Accidental Injury;
b. Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury;
c. Necessary to restore or improve a bodily function;
d. Necessary to correct a birth defect for covered Dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered by the Plan; or
e. Reconstructive breast surgery as described in section 4.B.9.

65. Screening Mammograms. The Plan provides Benefits for annual screening mammograms for Members who are women 40 years of age and older. The Plan also provides Benefits for additional radiological procedures recommended by a Provider when the initial screening mammogram results are not definitive.

66. Second Opinions. The Plan provides Benefits for second opinions when provided by a Plan Provider with no practice association with the original Provider. Prior Approval is required for second medical/surgical opinions provided by a Provider who does not participate with the Plan.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

67. Skilled Nursing Facility Services. The Plan provides Benefits for Inpatient Skilled Nursing Facility services with Prior Approval. The Plan does not cover Custodial Care.

68. Speech Therapy. The Plan provides Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to limits as described on your *Benefits and Prescription Drugs Schedule*. Prior Approval is required for the 9th visit and beyond.

Please visit [www.maineoptions.org] for more information on services that require Prior Approval or call Member Services at [1-855-624-6463 (TTY/TDD: 711)].

No Benefits are provided for:

a. Deficiencies resulting from intellectual disabilities; or
b. Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

69. Surgical Services. The Plan covers surgical procedures, including services of a surgeon, Specialist, anesthesiologist, or anesthetist, and for preoperative and postoperative care.

70. Telemedicine Services. The Plan covers Medically Necessary telemedicine services for the purposes of diagnosis, consultation, or treatment in the same manner as an in-person consultation between you and a Provider. Telemedicine services are limited to the use of HIPAA-compliant, real-time interactive audio, video, or electronic media communications as a substitute for in-person consultation with Providers.

    Out-of-Pocket Costs for telemedicine services are the same as the Out-of-Pocket Costs for the same type of service if it had been provided through an in-person consultation.

71. Tobacco Cessation. The Plan provides Benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for tobacco cessation. To be eligible for Benefits, these products and medications must be prescribed by your Provider for Tobacco Cessation purposes. NRT products can include, but are not limited to, nicotine patches, gum, or nasal spray.

    The Plan provides Benefits for tobacco cessation programs, follow-up education, and counseling.

    When prescribed by a Plan Provider, generic nicotine replacement therapy is available with no Out-of-Pocket Costs. Chantix is covered for the initial 30 days with two refills for a total 90 days supply in any plan year with no Out-of-Pocket Costs. For the current list of approved programs and medications, visit [www.maineoptions.org].

5. EXCLUSIONS FROM BENEFITS

The Plan will not provide Benefits for: (1) anything that is not Medically Necessary, (2) anything provided before or after the effective date of coverage (except as required by law), (3) non-Covered Services and any services, items, or charges related to non-Covered Services, (4) services, supplies, and any charges from a non-Provider or an excluded Provider, and (5) services and supplies to the extent that you do not have to pay or you have the right to recover expenses through a federal, state, county, or local law (even if you waive or do not assert your rights).

The following list of services and supplies are not Covered Services and the Plan will not provide Benefits for them. These exclusions are in addition to other exclusions listed in this Agreement. If you pay for a non-Covered Service, it will not count toward your Out-of-Pocket Cost limits.

1. Acts of War. Benefits are not provided for any illness or injury that is a result of war, declared or undeclared, or any act of war.

2. Alternative and Complementary Treatment and Therapy. The Plan does not provide Benefits for alternative or complementary treatments and therapies for which clinical effectiveness has not been proven as determined by MCHO's Chief Medical Officer. These include, but are not limited to:

    a. Acupuncture,
    b. Biofeedback,
    c. Holistic medicine,
    d. Homeopathy,
    e. Hypnosis,
    f. Aroma therapy,
    g. Reiki therapy,
    h. Massage therapy (except as part of an active course of treatment),
    i. Herbal, vitamin or dietary products or therapies,
    j. Naturopathy,
    k. Thermography,
    l. Orthomolecular therapy,
    m. Contact reflex analysis,
    n. Bioenergial synchronization technique, and
    o. Iridology.

3. Artificial Heart Devices. Artificial or mechanical hearts or heart assist devices are not covered as a Benefit. This exclusion does not include pacemakers or defibrillators. In addition, services and supplies for treatment of a heart condition while such devices remain in place are also not covered. The only exception is for left ventricular assist devices that are being used temporarily while awaiting heart transplant.

4. Blood. The Plan does not provide Benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

5. Commercial Diet Plans and Programs. The Plan does not provide Benefits for commercial diet plans or weight loss programs except as specifically approved by MCHO and covered under this Agreement.

    This exclusion does not apply to Medically Necessary treatments for Obesity. See section 4.B.48.

6. Cosmetic Services. Except for reconstructive services described under section 4.B.64, the Plan does not provide Benefits for Cosmetic Services.

7. Custodial Care. The Plan does not provide Benefits for services, supplies, or charges for Custodial Care, Domiciliary Care, or convalescent care.

8. Dental Care. Except as covered under section 4.B, the Plan does not provide Benefits for dental services, including but not limited to dental surgery, dental implants, or Orthognathic Surgery.

9. Experimental or Investigational Services. The Plan does not provide Benefits for any drugs, supplies, services, or equipment that are Experimental or Investigational as defined in this Agreement. The Plan does not provide Benefits for costs related to the provision of Experimental or Investigational drugs, supplies, services, or equipment. These exclusions do not apply when coverage is required by law.

10. Food or Dietary Supplements. The Plan does not provide Benefits for nutritional or dietary supplements unless covered in this Agreement or required by law. This exclusion includes, but is not limited to, over-the-counter nutritional formulas and dietary supplements.

11. Gender Reassignment (Sex Changes). The Plan does not provide Benefits for any services related to any gender reassignment (sex changes).

12. Government Services and Supplies. When services and supplies are provided by a facility owned or operated by federal, state, county, or local government, Benefits are not provided under the Plan. The Plan does not provide Benefits for services and supplies (1) provided by the U.S. Department of Veterans Affairs to veterans for a service-connected disability, or (2) provided by a uniformed services facility (unless you are a military dependent or retiree).

13. Gym or Spa Memberships. The Plan does not provide Benefits for health spas, gym memberships, health club memberships, exercise equipment, physical fitness or personal training, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Provider.

14. Hearing Care. The Plan does not provide Benefits for routine hearing examinations except for screening Members under the age of 19 years or when related to injury or disease and otherwise covered under this Agreement. Please see section 4.B.29 for Benefits for Hearing Aids.

15. Infertility; Surrogacy. The Plan does not provide Benefits for fertility drugs, Diagnostic Services, procedures, treatment, or other services or costs related to Infertility. This exclusion also applies to drugs used to enhance fertility.

    The Plan does not provide Benefits for services, supplies, or costs associated with surrogacy pregnancies. The Plan does not provide Benefits for the bearing of a child by another woman for an infertile couple.

16. Maintenance. The Plan does not provide Benefits for maintenance services, treatments, or therapy. This exclusion does not include Maintenance Medications.

17. Miscellaneous Expenses; Extra Services; Missed Appointments; Travel Costs.

    a. The Plan does not provide Benefits for Provider charges to provide required information to process a claim or application for coverage. The Plan does not provide Benefits for Appeal costs other than costs MCHO must pay under law.
    b. The Plan does not provide Benefits for extra services from your Provider. These extra services are sometimes called "concierge services." These extra services may include:
        (i) Telephone access to your Provider 24 hours a day, 7 days a week;
        (ii) Having a Provider accompany you to appointments with Specialists;
        (iii) Guaranteed same-day appointments when not Medically Necessary; and
        (iv) Making travel arrangements for you.
    c. The Plan does not provide Benefits for fees you are charged for missed appointments.
    d. The Plan does not provide Benefits for any travel costs, whether or not the travel is recommended by a Provider.

18. Orthognathic Surgery. The Plan does not provide Benefits for Orthognathic Surgery, except as covered under section 4.B.64.

19. Orthotic Devices; Shoe Inserts. The Plan does not provide Benefits for Orthotic Devices except as covered in section 4.B.53. The Plan does not provide Benefits for shoe inserts.

20. Personal Comfort and Convenience. The Plan does not provide Benefits for any personal comfort or convenience items, including but not limited to television rentals, television service, newspapers, telephones, telephone service, or guest services.

21. Personal Enrichment. The Plan does not provide Benefits for any of the following services or any services relating to:

    a. Sensitivity training;
    b. Recreational or social programs;
    c. Sports camps and other camps;
    d. Life coaching;
    e. Encounter groups;
    f. Educational programs except those provided in section 4.B;
    g. Guidance and career counseling; or
    h. Relaxation activities.

22. Physical and Occupational Therapy. The Plan does not provide Benefits for treatment such as massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment. Please see section 4.B.57.

23. Preventive Care. The Plan does not provide Benefits for preventive care and well-care services, unless otherwise stated in the "Covered Services" section. Please see section 4.B.60.

24. Prostheses. The Plan does not provide Benefits for dental prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg, that are designed exclusively for athletic purposes. Please see section 4.B.62.

25. Refractive Eye Surgery. The Plan does not provide Benefits for refractive eye surgery, such as radial keratotomy or laser surgery, for vision conditions that can be corrected by glasses, contact lenses, or means other than surgery.

26. Relatives or Volunteers. The Plan does not provide Benefits for any services or supplies provided to you by immediate family members or step-family members. Services performed by volunteers are not covered, except as provided under section 4.B.32

27. Reversing Voluntarily Induced Sterility. The Plan does not provide Benefits for services to reverse voluntarily induced sterility.

28. Routine Circumcisions. The Plan does not provide Benefits for routine circumcisions.

29. Routine Foot Care. The Plan does not provide Benefits for routine foot care.

30. Speech Therapy. The Plan does not provide Benefits for any speech therapy for deficiencies resulting from intellectual disabilities or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors. Please see section 4.B.68.

31. Temporomandibular Joint Syndrome ("TMJ"). The Plan does not provide Benefits for services for the evaluation, diagnosis, or treatment of TMJ, whether medical or surgical.

32. Vision Care. The Plan does not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises.

    Except as provided under section 4.B, the Plan does not provide Benefits for the prescription, fitting, or purchase of glasses or contact lenses.

33. Workers' Compensation. The Plan does not provide Benefits for services, supplies, or equipment for work-related illness, injury or disability that is due to an occupational disease for those with coverage under the workers' compensation or other programs of similar nature. If MCHO pays for services that are covered under workers' compensation we reserve the right to recover payment from the Provider and/or the liable party.

    If, under State law, you are allowed to waive all workers' compensation coverage, we will provide Benefits under this Plan.

6. CASE MANAGEMENT AND UTILIZATION REVIEW

A. Introduction

MCHO is committed to ensuring Members receive high quality, medically appropriate care. An important part of the Plan is our medical management and care management services. Our medical management team performs utilization review of health services to ensure they are medically necessary, evidence-based and delivered in the most effective healthcare setting.

If you are hospitalized, have been to the emergency department, have complex or serious health conditions, or are transitioning from one health care facility to another, our care management team will review your situation and determine whether you may benefit from case management services. These services are provided to you at no additional Out-of-Pocket Cost.

When you are hospitalized, our care managers will monitor your care to ensure you receive high quality services that are most appropriate for your condition. We will also work closely with the Hospital staff to help plan your discharge from the Hospital to help make it a smooth transition and provide you with access to the health care services that are most appropriate for your condition. Our care managers work closely with your Primary Care Provider and local care management teams to coordinate your care. Our care managers can coordinate your Specialist appointments and help you and your Providers go through the Prior Approval process, if applicable.

MCHO applies objective and evidence-based criteria and takes individual circumstances and local delivery system into account when determining the medical appropriateness of health care services. Under extraordinary circumstances that involve complex care or case management services the Plan may provide Benefits for services that are not listed in the "Covered Services" section (4.B). The Plan may also continue Covered Services beyond the contractual Benefit limit of this Agreement. These decisions are made on individual basis and a decision to provide alternate services or continue Benefits is not precedent setting, and it does not obligate us to continue to provide those Benefits to you or any other Member in the future. We reserve the right, at any time, to change or stop providing alternate service Benefits or extended Benefits. Should we decide to change or stop your alternate services, we will notify you of that decision in writing.

Members, their caregivers, or Providers can refer Members for complex case management consideration by contacting Member Services at [1-855-624-6463].

Disease Management

We proactively identify Members with, or at risk for, chronic medical conditions. Our Disease Management program supports the provider-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management.

Members, their caregivers, or Providers can refer Members for disease management consideration by contacting Member Services at [1-855-624-6463].

Wellness and Health Promotion

All Members have access to an online portal that provides information on over 6,000 health topics, tests, and wellness issues. In addition, Members have access to a Health Coach 24 hours per day 7 days per week to help you tackle some of your biggest health goals.

Earn incentives for activities that you choose based on your health goals and personal preferences. Examples include:

- Completing a Well-Being Assessment
- Working on quitting Tobacco or remaining Tobacco Free
- Getting recommended preventive care: annual physical, cholesterol screening, cancer screening, childhood immunizations
- Eating more fruits and vegetables
- Increasing activity or watching less TV
- Understanding a health condition
- Keeping an up-to-date medication list

To learn more about our Wellness and Health Promotion programs, and how you can earn points towards incentives, go to our website at [www.maineoptions.org] or contact Member Services at [1-855-624-6463].

Health Coaching

Our Health Coaching programs are delivered by seasoned Health Coaches who are available 24 hours a day, 365 days a year to Members directly through our online portal via click to chat, a secure, online message center or via a toll-free telephone number. Health Coaches employ a primary, whole person approach, and serve as a single point of contact to support individuals across a broad spectrum of healthcare needs including lifestyle risk, preference sensitive conditions and chronic condition management, including gaps in care.

Members can contact Member Services at [1-855-624-6463] or go to our website at [www.maineoptions.org] to enroll in our wellness programs.

Health Information Line

We provide Members with access to a nurse health information line 24 hours per day, 7 days per week. Members can speak with healthcare professional by calling [xxx-xxx-xxxx].

B. Reviews of Hospital Admissions

1. Generally

With the exception of Medical Emergency and maternity Hospital admissions, MCHO requires that we be notified before you are admitted to the Hospital.

For Medical Emergency and maternity Hospital admissions, you, your Designee, or your Provider must notify us within 48 hours after admission. We will conduct a review of your admission. The results of our review will be provided to you and your Provider within two business days (or any shorter period as required by law) after receiving all needed information.

Should you be admitted due to a Medical Emergency to a Hospital that is a Non-Plan Provider, your Out-of-Pocket Costs will be at the Plan Provider level only until your condition reasonably allows you to be transferred to a Hospital that is a Plan Provider. If you decide to stay beyond the time that you can be transferred to a Plan Provider Hospital, the rest of your Inpatient Stay Out-of-Pocket Costs will be at the Non-Plan Provider level.

2. While You Are in the Hospital

We will periodically review your Inpatient Stay at the Hospital while you are still in the Hospital. We want to ensure that you are receiving a proper level of care in the proper setting.

3. End of Benefits

When we decide that the Plan will no longer cover your Inpatient Stay at the Hospital, we will notify you and your Provider. We will explain the reason(s) behind our decision and when the Plan will no longer provide Benefits. Any Inpatient Stay beyond this time will not be covered by the Plan and you may be personally responsible for any costs relating to the continued Inpatient Stay.

C. Reviews of Observation Status

If you have not been admitted to Hospital but are registered by the Hospital for observation, this means that the Hospital staff is monitoring your health status while awaiting test results. Based on that monitoring and testing you may be admitted as an Inpatient or discharged home for follow up with your personal Provider as an Outpatient.

7. BENEFIT DETERMINATIONS, PAYMENT, AND CLAIMS

A. Benefit Determinations

The Plan, or a person or entity working on behalf of the Plan, will administer your Benefits and determine your Benefits in accordance with the terms of this Agreement. If you

disagree with a determination made by the Plan, you may submit complaints and Appeal the decision as described in section 9.

B. Payment for Provider Services

1. Plan Providers

If your claim from a Plan Provider is approved, the Plan will pay Benefits directly to the Plan Provider. Except for your Out-of-Pocket Costs, if applicable, you are not required to pay any balances to the Plan Provider until the Plan determines what it will pay.

2. Non-Plan Providers

If you receive Covered Services from a Non-Plan Provider, the Plan will make a determination of whether it will pay Benefits. If the Plan approves your claim for payment of services rendered by a Non-Plan Provider, the Plan will pay Benefits up to the Maximum Allowable Charge. We will pay Benefits directly to you or to the Non-Plan Provider.

You may be billed by the Non-Plan Provider, and you may have to pay the balance if the claim is for more than the Maximum Allowable Charge. This is sometimes called Balance Billing. Before you receive a service, you may call MCHO toll-free at [1-855-624-6463 (TTY/TDD: 711)] to learn the Maximum Allowable Charge for a service. If we deny your claim, you have the right to appeal our decision by following the steps in section 9. For Medical Emergency services rendered by a Non-Plan Provider, your Out-of-Pocket Costs will be the same as though you received care from a Plan Provider.

C. Out-of-Pocket Costs

1. Copayments and Coinsurance

You may have some responsibility for the cost of Covered Services under this Agreement and the *Benefits and Prescription Drugs Schedule*. Your responsibility may come in the form of Copayments and Coinsurance. These should be paid directly to the Provider. If you have Coinsurance responsibility, you will pay your Coinsurance percentage based on the Provider's discounted or negotiated charges with MCHO, if any.

2. Deductible

Members may be responsible for paying a yearly Deductible amount described in each Member's *Benefits and Prescription Drugs Schedule*. Each Calendar Year, before the Plan pays Benefits for many Covered Services, Members must pay the

applicable Deductible. Expenses for non-Covered Services will not apply to the Deductible.

If you receive Covered Services during the last three months of the Calendar Year and charges for these Covered Services are applied toward that year's Deductible, then these same charges will also be applied toward the Deductible for the following year.

a. Family Deductible. Under family coverage, if the total family expenses for Covered Services exceed two times the individual Deductible, then your family Deductible under this Agreement has been met for the Calendar Year. In this case, you and your Dependents will be eligible for Benefits for the rest of the Calendar Year without having to pay further Deductibles.

b. One Deductible For a Common Accident. Under family coverage, if two or more family members are injured in the same accident, only one Deductible will apply for all Covered Services resulting from that accident during a Calendar Year.

3. Out-of-Pocket Limits

Member annual Out-of-Pocket Costs for Copayments, Coinsurance, and Deductibles may be limited. Please see the *Benefits and Prescription Drugs Schedule* for details on any Out-of-Pocket Cost limits.

4. Benefit Maximums

Certain Covered Services may have maximum Benefits. Please see the *Benefits and Prescription Drugs Schedule* for details on these maximums.

5. Plan Providers vs. Non-Plan Providers. Please note that your Out-of-Pocket Costs for Covered Services may be higher when Covered Services are provided by a Non-Plan Provider. This is described in more detail in your *Benefits and Prescription Drugs Schedule*. Under Maine law, the difference between your Out-of-Pocket Costs for Covered Services provided by a Plan Provider and a Non-Plan Provider cannot be more than 20%. When you receive services for a Medical Emergency, your Out-of-Pocket Costs will be the same whether you see a Plan Provider or a Non-Plan Provider.

D. Claims (Proof of Loss) Procedures

1. Claims Generally

Plan Providers will file claims directly with the Plan. Members may need to submit a claim for reimbursement for services from a Non-Plan Provider. If you need to submit a claim for a service, you or your Designee must do so within 120

days after the service is rendered. However, you may be allowed extra time if there is good reason why the claim cannot be submitted on time, and if you submit the claim as soon as you reasonably can.

You may obtain a medical or prescription drug claim form at [www.maineoptions.org] or by calling Member Services at [1-855-624-6463 (TTY/TDD: 711)]. The form will include instructions on what information you will need to submit to the Plan so that the Plan can make a decision on the claim. Please return the completed claim form along with copies of any receipts or invoices to the address on the form.

If we do not furnish these forms to you within 15 days after we receive your request, you may meet the proof requirements by giving us a written statement of the nature and extent of the claim within 120 days after the service is rendered.

If you have paid a Provider for Covered Services and want the Plan to reimburse you directly, please send the receipts from the Provider to show proof of payment. Benefits will be paid to the Member who received the services for which a claim is made unless the Member is a minor. In this case, Benefits will be paid to the parent or custodian with whom the minor resides. The Member may authorize MCHO to pay Benefits directly to the Provider who charged for the service subject to the claim.

Any payment made by MCHO in accordance with the terms of this Agreement will discharge MCHO from all further liability to the extent of such payment.

2. Payment Limits

The Plan limits what it will pay for Covered Services not provided by a Plan Provider. The most the Plan will pay is the Maximum Allowable Charge. The Plan will pay accepted claims immediately. You may have to pay the balance if the claim is for more than the Maximum Allowable Charge. The Plan will pay Benefits within 30 days after receipt of the claim and proof supporting the claim.

8. OTHER COVERAGE

A. Other Insurance Coverage – Generally

If you receive services that are covered by the Plan and that are also covered by another payment source, your Benefits will be coordinated with the other payment source. This is called coordination of benefits ("COB"). Your Benefits may also be subject to something called "subrogation." Both of these items are explained below. The purpose of COB and subrogation is to prevent duplicate recovery for the same service. This section does not provide coverage for any service or supply that is not expressly covered under this Agreement, nor increase the level of coverage provided under this Agreement.

B. Coordination of Benefits

Benefits under this Agreement and the *Benefits and Prescription Drugs Schedule* will be coordinated to the extent permitted by law with other types of insurance coverage that pay for health care services and supplies. These other types of coverage may include:

- Auto insurance;
- Homeowners' insurance;
- Government benefits;
- Medicare; and
- Health plans ("Health Plans"), including, group and non-group health insurance contracts, health maintenance organization plans, nonprofit medical or hospital service corporation plans, and self-insured plans.

There is no COB with Medicaid.

When there is COB, it will be based upon the Maximum Allowable Charge for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a Provider is paid under a capitation arrangement, COB will be based on the reasonable value of such services.

When a Member is covered by more than one Health Plan, one plan will be primary and all other plans will be secondary. The primary plan pays benefits first as though there was no other coverage. The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits. To the extent required by law, when a Member is covered by more than one Health Plan, payments made by the primary plan, payments made by the Member, and payments made from a health savings account or similar fund for benefits covered under the secondary plan will be credited toward the deductible of the secondary plan.

1. <u>COB Rules for Health Plans</u>

   When you have coverage of benefits through the Plan and also through one or more other Health Plans, and if the other Health Plan(s) does not contain a COB clause or does not allow COB with this Agreement, the benefits of the other Health Plan will be primary.

   If both this Agreement and the other Health Plan(s) contains a COB clause allowing the COB with this Agreement, MCHO will determine benefit payments by using the first of the following rules that applies:

   a. <u>Non-Dependent/Dependent</u>: The benefits of the contract that covers the person as an employee or subscriber will be determined before the benefits of the contract that covers the person as a dependent are determined.

b. Dependent Children with Parents Not Legally Separated or Divorced: For claims on covered dependent children, the contract of the parent whose birthday is earlier in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this Agreement will determine the order of benefits.

c. Dependent Children with Parents Legally Separated or Divorced: In the case of legal separation or divorce, the coverage of the parent with custody of the dependent will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Unless there is a court decree (known to MCHO) specifying the parent who is financially responsible for the dependent child's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of Benefits is determined by following rule (b) above.

d. Active/Inactive Employee: The Benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other Health Plan does not include this provision, and as a result, the contracts do not agree on the order of Benefits, rule (f) below applies.

e. COBRA or Continuation of Coverage: If a person whose coverage is provided under the right of continuation pursuant to COBRA or another Federal or State law is also covered by another contract, the Benefits of the contract covering the person as an employee, member, or Subscriber, or as the Dependent of an employee, Member, or Subscriber, will be primary. The Benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule (f) below applies.

f. Longer/Shorter Length of Coverage: If none of the above rules determines the order of Benefits, the Benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

With respect to COB, MCHO may exercise its rights to carry out COB without providing notice to, or obtaining consent from, Members. MCHO may share information with another insurance company or party to determine COB and take

steps to recover the Plan's excess payment from another party or pay another party for its excess payment. MCHO reserves the right to suspend payment on a claim when the Plan is secondary until the Provider has submitted the claim to the primary plan and the primary plan has either paid or denied the claim. Nothing in this Agreement shall be interpreted to limit MCHO's right to use any remedy provided by law to enforce MCHO's rights to COB under this Agreement.

2. COB for Workers' Compensation, Government Benefits, and Other Insurance Coverage

If MCHO pays Benefits for services for an illness or injury covered under workers' compensation or a similar program, or a government benefit, to the extent allowed by law MCHO may recover its expenses from Providers MCHO pays or from one or more third parties.

For Members who are entitled to Benefits under the medical payment benefit of another insurance policy (e.g., auto, homeowners'), that policy will be primary to the Plan's coverage with respect to a covered loss under that policy. All payments for services provided by the Plan to Members that are covered under any such medical payment policy or Benefit are payable to MCHO.

3. Medicare

If you are eligible for Medicare Part A, you must contact Member Services and let us know. You may remain an enrolled Member under the Plan even if you are enrolled in Medicare. To the extent allowed by law, your Benefits under the Plan will not duplicate any Benefits that you receive under Medicare Part A or Part B regardless of whether you actually exercise your rights to Medicare Part A or Part B.

C. Subrogation

When a third party is legally responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When we provide Benefits for treatment of such injury or illness, we have the right to recover, on a just or equitable basis, from any such payment (whether or not such payment is for medical expenses) up to 100% of the Benefit we paid. We also have subrogation rights against your other insurance coverage, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy. We reserve the right to recover from a Member up to 100% of the value of Benefits, on a just and equitable basis, provided or paid for by the Plan when a Member has been, or could have been, reimbursed for the cost of care by a third party. If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services. Nothing in this Agreement shall be interpreted to limit MCHO's right to use any remedy provided by law to enforce MCHO's rights to subrogation under this Agreement. Before we will enforce our subrogation rights, we will first obtain your prior written approval.

D. Cooperating with MCHO

As a Member under the Plan, you agree to cooperate with us in exercising our rights of subrogation and COB under this Agreement. MCHO agrees that subrogation payments will be made on a just and equitable basis. Your cooperation may include:

a. Telling us when there is a possible legal action or claim that may implicate MCHO's subrogation or COB rights;
b. Giving us information and documents that we request;
c. Assigning to MCHO payments that you receive for services paid by MCHO;
d. Signing documents deemed necessary by MCHO to protect its subrogation and COB rights, including, but not limited to, providing MCHO with your prior written approval of MCHO enforcing its subrogation rights; and
e. Not taking any action that would impede MCHO's subrogation or COB rights.

If you do not cooperate with MCHO as provided in this section 8.D, you may be liable to MCHO if MCHO needs to enforce its rights. You may also be liable for MCHO's costs and reasonable legal fees.

9. APPEALS AND COMPLAINTS

A. Contacting MCHO's Member Services

MCHO's Member Services representatives are available to assist Members in the resolution of complaints. If you have a complaint about a claim denial, we recommend that you contact a Member Services representative before filing an Appeal. Sometimes, a claim denial is caused by a minor error or problem that can be resolved by a Member Services representative without having to go through the appeal process.

You may call to make a complaint to Member Services at [1-855-624-6463 (TTY/TDD: 711)]. You can also make a written complaint by mailing or faxing it to:

[Maine Community Health Options
Attn: Member Services
P.O. Box 1121
Lewiston, ME 04243]

Fax: [xxx-xxx-xxxx]

After we receive your complaint, a Member Services representative will look into and respond to your complaint. If you disagree with our response, you may be able to file an Appeal of the decision. Decisions subject to the Appeal process are Adverse Benefit Determinations, Adverse Health Care Treatment Decisions, and Adverse Benefit Determinations not involving Health Care Treatment Decisions. Please contact Member Services if you have questions.

B. MCHO's Appeal Process

This section describes MCHO's internal Appeal process and the external independent review process. If you receive an Adverse Benefit Determination, Adverse Health Care Treatment Decision, or Adverse Benefit Determination not involving a Health Care Treatment Decision, you may file an Appeal. Your Appeal will be decided by one or more persons not involved in making the decision that you are appealing. You may have a Designee or your Provider assist you with your Appeal. Please follow the steps described below.

Members who are visually and/or hearing impaired may request complaint and Appeal process materials in an appropriately accessible format by contacting MCHO Member Services at [1-855-624-6463 (TTY/TDD: 711)].

1. Beginning Your Appeal

To begin your Appeal, please contact Member Services by mail, phone call, or fax. You will need to give us specific information about your Appeal, including:

a. Which decision(s) you are appealing;
b. Why you disagree with the decision(s); and
c. What you would like the outcome to be.

We may need to review your medical records, billing statements, and other documents to decide your Appeal. If we need more information (such as medical records, bills, or other documents) to process your Appeal, your Appeal Coordinator will let you know.

If you wish to appeal an Adverse Benefit Determination, Adverse Health Care Treatment Decision, or Adverse Benefit Determination not involving a Health Care Treatment Decision, you must submit your Appeal to MCHO within 180 days from the date of the decision you wish to appeal. If you do not submit an Appeal within this time limit, you will lose your right to appeal the decision unless the delay is reasonable under the circumstances and does not negatively prejudice MCHO's rights.

Please send your Appeal to:

[Maine Community Health Options
Attn: Member Services
P.O. Box 1121
Lewiston, ME 04243]

Telephone: [1-855-624-6463 (TTY/TDD: 711)]
Fax: [xxx-xxx-xxxx]

After we receive your Appeal, we will assign an Appeal Coordinator to manage your Appeal throughout the entire appeal process. We will send you a letter

identifying your Appeal Coordinator within three business days after we receive your Appeal. The letter will describe the appeal process and your rights in more detail. Please contact your Appeal Coordinator if you have questions.

Your appeal rights include:

a. Being allowed to review the claim file and to present evidence and testimony as part of the appeals process;

b. Being given, free of charge, any new or additional evidence considered, relied upon, or generated by MCHO (or at the direction of MCHO) in connection with the claim, unless the evidence is confidential or privileged. MCHO will give you the evidence as soon as possible and with enough time in advance of the decision to give you a reasonable opportunity to respond;

c. Before MCHO can issue a final adverse determination based on a new or additional reason, being provided with the reason, free of charge, with enough time in advance of the decision to give you a reasonable opportunity to respond; and

d. Receiving a notice from MCHO describing your appeal rights within three business days after MCHO receives your Appeal.

2. First Level Appeal Process

The first level appeal process involves either "standard review" or "expedited review."

Your Appeal will be eligible for an expedited review if your Appeal involves services that, if delayed, could seriously jeopardize your health or your ability to regain maximum function. We will grant an expedited review of any Appeal for services concerning (1) an Inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has received Medical Emergency services and has not been discharged from the Hospital where Medical Emergency services were provided. You, your Designee, or your Provider may request an expedited review.

a. Standard Review. Your Appeal Coordinator will investigate your Appeal. If your Appeal involves a medical determination, an appropriate clinical reviewer will review your Appeal.

After we receive all the information needed to make a decision, your Appeal Coordinator will notify you and your Provider in writing whether we have approved or denied your first level Appeal. We are able to make decisions in most Appeals within 20 business days after we receive the

Appeal request. If we cannot reasonably meet the 20 business-day time frame due to an inability to obtain necessary information from a Non-Plan Provider, we will let you and your Provider know that we are requesting more time and why we need more time. We will make the decision on your Appeal and notify you within 10 days after receiving all necessary information, unless you voluntarily agree to extend the time frame beyond this.

b. Expedited Review. We will investigate and complete expedited review of first level Appeals within 72 hours after we receive your Appeal. We will make a decision sooner if we can. It is critical that you provide all necessary information so that we can complete the expedited review quickly. For expedited Appeals involving (1) continued Medical Emergency services to screen or stabilize a Member, or (2) continued care under an authorized admission or course of treatment, coverage will be continued without liability to the Member until the Member has been notified of the expedited appeal decision. We may call you and your Provider to tell you our expedited appeal decision. We will also send our written decision to you and your Provider within two working days after calling you.

c. Denial of First Level Appeal. We will notify you of our first level appeal decision. If we deny your first level Appeal, we will give you a written decision, which will include:

(i) The reason(s) for the decision;
(ii) Who made the decision;
(iii) Reference to the specific Agreement provisions, other documents, and evidence used to make the decision;
(iv) How you can obtain free copies of information relevant to the decision;
(v) Notice of your right to contact the Maine Bureau of Insurance by telephone at **1-800-300-5000** (within Maine) or **1-207-624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333;
(vi) How to obtain a second level review;
(vii) How to obtain an independent external review; and
(viii) How to contact the ombudsman, Consumers for Affordable Health Care, by telephone at **1-800-965-7476** or by mail at P.O. Box 2490, Augusta, ME 04338-2490.

3. Second Level Appeal Process (Voluntary)

If you disagree with the decision of the first level appeal process, you may request a second level Appeal. Your second level Appeal will be reviewed by an MCHO review panel. You must make a second level Appeal within 180 days after the

date of the first level appeal decision. If you do not submit a second level Appeal within this time, you will lose your right to a second level Appeal unless the delay is reasonable under the circumstances and does not negatively prejudice MCHO's rights.

You may waive your right to the second level appeal process and request an independent external review as provided below.

You have a right to attend the meeting to present your case to the review panel. You or your Designee must tell your Appeal Coordinator if you wish to attend. You may also participate in the meeting by telephone or video conferencing if you wish – please let your Appeal Coordinator know.

You may submit supporting materials both before and at the review meeting and you may ask questions of MCHO representatives. You also may bring someone with you or be represented by someone, including a lawyer, at the review meeting. You also have the right to obtain free of charge from MCHO your case file and information relevant to your Appeal that is not confidential or privileged.

If you request to participate in the review panel, we will hold a review meeting within 45 business days after we receive your request for a second level Appeal. You will be notified in writing at least 15 business days in advance of the review meeting. We will let you know if MCHO will have a lawyer presenting MCHO's case. If you need to postpone the review meeting, please let your Appeal Coordinator know.

The decision of the review panel will be sent to you in writing within five working days after a review meeting.

If you do not request to participate in the review panel, you will be provided with a written response to your second level Appeal within 30 calendar days after we receive your request for a second level Appeal.

If we deny your second level Appeal, we will give you a written decision, which will include:

(i) The reason(s) for the decision;
(ii) Who made the decision;
(iii) Reference to the specific Agreement provisions, other documents, and evidence used to make the decision;
(iv) How you can obtain free copies of information relevant to the decision;
(v) Notice of your right to contact the Maine Bureau of Insurance by telephone at **1-800-300-5000** (within Maine) or **1-207-624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333;

(vi) How to obtain an independent external review; and
(vii) How to contact the ombudsman, Consumers for Affordable Health Care, by telephone at **1-800-965-7476** or by mail at P.O. Box 2490, Augusta, ME 04338-2490.

4. Independent External Review

Appeal decisions involving an Adverse Utilization Determination or an Adverse Health Care Treatment Decision by MCHO are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. Adverse Utilization Determinations for purposes of independent external review include Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered Benefit, Experimental or Investigational treatment or services, and rescission.

The external review decision must be made within 30 days after the independent review organization receives the request for the review. However, the decision must be made within 72 hours if delay would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.

If the independent review organization decides in your favor, the decision is binding on MCHO.

Normally, you must first complete MCHO's first and second level appeals process to be eligible for independent external review. However, you are not required to complete the first and second level appeals process if:

a. MCHO has failed to make a decision on your first or second level Appeal in the time frames noted above;
b. MCHO has not followed all the federal and state requirements applicable to MCHO's internal appeal process;
c. You have applied for expedited external review at the same time as applying for an expedited internal Appeal;
d. You and MCHO mutually agree to bypass the MCHO appeals process, or with respect to a second level Appeal you waive your right to a second level Appeal;
e. Your life or health is in serious jeopardy;
f. The Member for whom external review is requested has died; or
g. The Adverse Utilization Determination or Adverse Health Care Treatment Decision concerns an admission, availability of care, a continued stay, or health care services when the Member has received Medical Emergency services but has not been discharged from the facility that provided the Medical Emergency services.

You may obtain review under this section even though you have failed to obtain Prior Approval prior to receiving a Covered Service.

You must request external review by making your request in writing to the Maine Bureau of Insurance at 34 State House Station, Augusta, ME 04333. You must also make your request within 12 months after MCHO's final denial of Benefits under our internal appeals process. You will not be charged a fee to initiate external review. You may have someone else make this written request for you if this person:

a. Has your written consent to make the request;
b. Is authorized by law to make the request on your behalf; or
c. Is your family member or treating Provider, but only if you are unable to make the request.

5. Second Opinions. In any Appeal in which a professional medical opinion regarding a health condition is a material issue in the dispute, you may be entitled to an independent second opinion from a Provider of the same specialty, paid for by the Plan.

C. Complaints

If you have any complaints about MCHO's services or your Plan, please contact Member Services:

[Maine Community Health Options
Attn: Member Services Department]
P.O. Box 1121
Lewiston, ME 04243]

Telephone: [1-855-624-6463 (TTY/TDD: 711)]
Fax: [xxx-xxx-xxxx]

We will respond to you as quickly as we can. Most complaints can be investigated and responded to within 30 days.

You may also submit complaints to the Maine Bureau of Insurance:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1-800-300-5000 (within Maine) or 1-207-624-8475 (outside Maine)

D. Legal Action against MCHO

A Member may only bring legal action against MCHO for an Adverse Utilization Determination or Adverse Health Care Treatment Decision if the Member or the Member's representative has exhausted the complaint and appeals process outlined in section 9. A Member must bring this type of legal action within 3 years from the earlier of: (1) the date of issuance of the written external review decision, or (2) the date of issuance of the underlying adverse first level appeal decision.

No action at law or in equity shall be brought to recover on this Agreement prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

10. TERMINATION

This Agreement will be in effect until it is terminated as provided by this Agreement and by Health Insurance Marketplace requirements, as applicable. Once your Agreement terminates, the Plan will not provide Benefits for Covered Services rendered after the effective date of termination.

A. Termination by Member

You may request that we end this Agreement and your coverage under the Plan at any time. This Agreement and your coverage will be terminated effective 14 days after we receive your written notice or any later time that you request. We may terminate this Agreement and your coverage with fewer than 14 days' notice from you if we are able to effectuate the termination at an earlier time and you ask us to effectuate the termination before the end of the 14 days. If you receive your coverage under the Plan through the Health Insurance Marketplace and you become eligible for coverage under Medicaid, the Children's Health Insurance Program, or a Basic Health Program, the termination will be effective the day before your new coverage starts.

We will refund to you Premiums paid for coverage for periods after the effective date of termination.

If you receive your coverage under the Plan through the Health Insurance Marketplace, you should notify the Health Insurance Marketplace that you want to end your membership. Please contact the Health Insurance Marketplace for more details.

B. Termination by MCHO

MCHO may terminate this Agreement and your coverage under the Plan as follows:

1. MCHO will give you thirty days' notice for:

    a. Failure to meet all of the eligibility requirements under this Agreement [and imposed by the Health Insurance Marketplace, as applicable];

b. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. In addition, MCHO may rescind this Agreement and your coverage as provided in section 10.C; and

c. Non-payment of Premium as provided in section 3.E; and

d. the Plan is terminated or no longer certified by the Health Insurance Marketplace

2. [If you switch coverage, MCHO will give you notice of termination as required by Federal law.]

We will refund to the Member Premiums paid for periods after the effective date of termination.

C. Rescission

MCHO reserves the right to rescind a Member's coverage as of the last date of eligibility for any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member. Any claims incurred after the date of eligibility for which MCHO is unable to recover payment from the Provider will be the responsibility of the Subscriber. MCHO will provide 30 days' prior written notice prior to rescinding coverage under this section 10.C.

D. Notice of Termination

You have the right to designate a third party to receive notice of termination of this Agreement, and to change the person you designate to receive such notice, by completing and sending to us a Third Party Notice Request form. Please contact Member Services at [1-855-624-6463 (TTY/TDD: 711)] to make or change such designation. We will send a Third Party Notice Request form to you within 10 days after you contact us.

E. Right to Reinstatement

1. Cognitive impairment or functional incapacity

Under Maine law, you may be eligible to reinstate the Agreement within 90 days after the termination if non-payment of Premium or other lapse or default took place because you suffered from cognitive impairment or functional incapacity at the time of termination. You, someone authorized to act on your behalf, or a Dependent may request reinstatement.

We may require you prove that you suffered from cognitive impairment or functional incapacity at the time of termination. This proof may include getting a medical examination at your own expense or giving us medical records. If you qualify for reinstatement under this section, we will reinstate your coverage without a break in coverage. We will reinstate your coverage as though it had not

been terminated. Your reinstated coverage will be subject to the same terms, conditions, exclusions, and limitations.

Before your coverage is reinstated, you must pay the amount due from the date of termination through the month in which we bill you within 15 days after we request that you make payment. If you do not pay in time, we are not required to reinstate your coverage and you will be responsible for claims incurred after the effective date of termination.

If we deny your request for reinstatement, we will send a notice to you and to the person who made the request, if different. You have the right to an Appeal under section 9, or to request a hearing before the Maine Bureau of Insurance, within 30 days after you receive the notice from us.

Notice of cancellation will be provided to you and your designated third party at least 10 calendar days before cancellation of this Agreement. Such notice shall include the reason(s) for cancellation, amount of unpaid Premium and the date by which the Premium must be paid, if applicable, and notice of the right to guaranteed issuance of individual health plans.

2. Acceptance of Premium

If coverage under this Agreement terminates due to non-payment of Premium, we require an application for reinstatement. We will advise you of the effective date of reinstatement by giving you written notice of the date. In any case, the reinstated coverage provides Benefits only for:

a. Injury occurring after the effective date of reinstatement; and
b. A condition first manifesting itself more than 10 days after the effective date of reinstatement.

F. Certificate of Creditable Coverage

When your coverage with MCHO ends a *Certificate of Creditable Coverage* will be provided to you. If your coverage changes outside of an Open Enrollment Period, you may need a *Certificate of Creditable Coverage* to prove that you are eligible for Special Enrollment. This document can be used to provide proof that you had health insurance coverage through MCHO for a specified period of time. You may ask for a copy of this document at any time provided that the request is made within 24 months following the termination of your coverage.

11. OTHER PROVISIONS

A. Assignment of Benefits

You may assign Benefits provided for Covered Services only to the Provider rendering services. You may not assign this Agreement to anyone else without our written permission.

B. Entire Agreement

This Agreement, the *Benefits and Prescription Drugs Schedule*, any [*Single Streamlined Application*], and any Riders make up the entire agreement between you and MCHO with respect to the subject matter contained in these documents.

C. Changes to this Agreement

This Agreement, the *Benefits and Prescription Drugs Schedule*, and applicable Riders may be amended by MCHO upon sixty (60) days' written notice to you. Amendments do not require the consent of Members. Amendments can only be made in writing by an authorized officer of MCHO. No agent has authority to change this Agreement or waive any of its provisions.

D. Non-enforcement

If MCHO does not enforce compliance with any provision of this Agreement, this non-enforcement shall not be deemed to be a waiver by MCHO of that provision or any other provision of this Agreement.

E. Relationship between MCHO and Providers

MCHO has separate contracts with Plan Providers. Plan Providers are independent contractors. They are not agents or employees of MCHO. Plan Providers may not modify this Agreement, the *Benefits and Prescription Drugs Schedule*, or any applicable Riders. Only MCHO may modify this Agreement as provided under section 11.C. Plan Providers cannot make binding promises on behalf of MCHO.

MCHO may change its arrangements with Plan Providers, including addition and removal of Plan Providers. MCHO will try to give you at least 60 days' notice before MCHO removes a Plan Provider. If it is impossible for MCHO to give you this much notice, MCHO will give you as much notice as possible.

MCHO does not render health care services, supplies, or equipment to Members. Instead, MCHO arranges Covered Services for Members and pays Benefits in accordance with this Agreement. It is Providers who render health care services, supplies, and equipment to Members. MCHO does not interfere with the independent medical judgment of Providers.

F. Notice

Any notice to a Member will be sent to the last address of the Member on file with MCHO. Notices to MCHO should be sent to:

[Maine Community Health Options

Attn: Member Services
P.O. Box 1121
Lewiston, ME 04243]

G. Disasters

In the event of a war, riot, epidemic, or other major disaster (natural or manmade) (together, "Disasters"), MCHO will try to arrange for services. MCHO is not responsible for the costs or outcome of its inability to arrange for services due to a Disaster.

H. Confidentiality of Member Information

MCHO is committed to ensuring and safeguarding the confidentiality of its Members' personal and medical information. We are subject to various federal and state laws regarding how we access, use, and disclose Member information. We will access, use, and disclose the minimum information necessary to accomplish the purpose of the task. We will only access, use, and disclose your information as allowed by law or obtain your specific permission to access, use, or disclose your information.

Examples of when we will need to access, use, and disclose Member information include:

1. Obtaining and sharing information with your Providers so we can perform Prior Approval activities;
2. Conducting quality activities;
3. Obtaining information from Providers so we can properly pay Benefits; and
4. When we are required or authorized by law to access, use, or disclose information.

MCHO sometimes contracts with other persons and entities to perform tasks on behalf of MCHO. MCHO requires these other persons and entities to comply with MCHO's policies on protecting Member information and applicable state and federal laws.

There may be times when MCHO needs your (or your Designee's) written authorization to disclose your information. This may be true even if you request that we disclose your information. In cases where we need written authorization, we will provide a copy of our written authorization form to you (or your Designee) to complete and sign.

We will protect your Protected Health Information as required by the Health Information Portability and Accountability Act ("HIPAA"). For more details on how we will handle your Protected Health Information, please see our Notice of Privacy Practices.

I. Providing MCHO with Information

The Member agrees that MCHO may have access to (1) all health records and medical data from Providers rendering care to Members, and (2) information about other types of insurance, such as auto insurance, Health Plans, and homeowners' insurance, and other sources

of payment for COB purposes. Sometimes, your Providers or other insurers may need your (or your Designee's) written authorization to disclose information to us. Please ask your Providers or other insurers about how to do this.

J. Time Limit on Certain Defenses

After 3 years from the date of this Agreement, no misstatements, except fraudulent misstatements, made by the Member in the [*Single Streamlined Application*] for this Agreement shall be used to void the Agreement or to deny a claim.

K. Physical Examination; Autopsy

We have the right and opportunity, at our own expense, to examine the Member when and as often as it may be reasonably required during the pendency of a claim hereunder and to make an autopsy in the case of death, unless forbidden by law.

L. Conformity with State Statutes

Any provision of this Agreement that, on its effective date is in conflict with the statutes of the State of Maine, is hereby amended to conform to the minimum requirements of such statutes.

M. Subcontractors

MCHO may subcontract with individuals and entities to provide services on behalf of MCHO. Subcontractors may include, but are not limited to, prescription drug benefit managers and behavioral health managers. Subcontracted duties may include Benefit determinations, paying claims, administrative services, or other duties.

N. Genetic Information

MCHO will not discriminate on the basis of genetic information as provided in the federal Genetic Information Nondiscrimination Act of 2008.

12. GLOSSARY

Accidental Injury. Accidental bodily injury sustained by a Member that is the direct cause of the condition for which Benefits are provided and that occurs while this Agreement is in force.

Advance Payments of Premium Tax Credit or Tax Credit. The federal tax credit available to eligible persons who apply for private insurance coverage through the Health Insurance Marketplace to help offset the costs of monthly Premiums.

Adverse Benefit Determination. By or on behalf of MCHO, any (1) Adverse Health Care Treatment Decision, or (2) denial reduction, or termination of, or a failure to provide or make

payment (in whole or in part) for, a Benefit, including an action based on a determination of a Member's ineligibility to participate in the Plan.

Adverse Health Care Treatment Decision. A health care treatment decision made by or on behalf of MCHO denying in whole or in part payment for or provision of otherwise Covered Services requested by or on behalf of a Member. Adverse Health Care Treatment Decisions include rescission determinations and initial coverage eligibility determinations as provided under federal law.

Adverse Utilization Determination. A determination by MCHO that: (1) an admission, availability of care, continued stay, or other health care service has been reviewed and does not meet MCHO's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; and (2) payment for the requested services is therefore denied, reduced without further opportunity for additional service, or terminated.

Ambulatory Surgery Center. A facility that is licensed by a state or certified by Medicare as an ambulatory surgery center.

Amendment. An addition, deletion, or revision to the terms and conditions of this Agreement.

Appeal. A request by a Member or the Member's designee to have MCHO review a decision as described in section 9 of this Agreement.

Appeal Coordinator. The individual who manages a Member's Appeal throughout the entire appeal process.

Applied Behavior Analysis. The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder. Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Balance Billing: When a Provider bills a Member for some or all of the remaining charges not paid by the Plan (this does not include Member Out-of-Pocket Costs).

Basic Health Program (BHP). A program under the Patient Protection and Affordable Care Act that allows states to offer subsidized coverage for certain individuals with low incomes. Not all states offer a Basic Health Program.

Benefits. Payments we make on your behalf under this Agreement and your coverage under the Plan.

Calendar Year. When your coverage first begins under the Plan, the Calendar Year is the effective date of your coverage through the earlier of (1) December 31 in the year your coverage first begins, or (2) the date your coverage ends. For years after the year in which your coverage first begins under the Plan, the Calendar Year is January 1 through the earlier of (1) the first occurring December 31, or (2) the date your coverage under the Plan ends.
Children's Health Insurance Program (CHIP). CHIP is a federal and state program that provides low-cost health insurance coverage for children in families who earn too much income to qualify for Medicaid coverage but can't afford to purchase private health insurance.

Chiropractor or Doctor of Chiropractic. A person who is licensed to perform chiropractic services.

Coinsurance. The percentage paid by a Member toward the cost of the Maximum Allowable Charge of some Covered Services.

Community Mental Health Center. An institution that is licensed as a comprehensive community mental health center.

Copayment. Fees payable by Members for certain Covered Services. Copayments are payable at the time of the visit or when billed by the Provider.

Cosmetic Services. Medical and surgical services intended solely for the purpose of changing or improving appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Services. Services, supplies, or treatment covered by this Agreement and as described in section 4.

Creditable Coverage (Prior Coverage). Coverage under an individual or group contract or policy that was in effect within 3 months before you were eligible for coverage under this Contract if you apply when initially eligible, or within 3 months of your effective date if you apply as a Late Enrollee. Creditable coverage includes Group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, qualified public health plan, the Peace Corps health benefit plan, CHIP, or a qualified foreign health plan. In calculating the period of Creditable Coverage, all periods of coverage under all types of Creditable Coverage are added together unless there is a consecutive 90-day or longer break in the time period the individual has Creditable Coverage.

Custodial Care. Services that are (1) not for the purpose of treating an illness or injury, and (2) for the purpose of assisting with activities of daily living. Such services include, but are not limited to, help with: personal hygiene, bathing, dressing, skin and nail care, toileting, preparing meals and feeding, walking or transferring positions, giving medicines that are typically self-administered, and catheter care. Services may be Custodial Care regardless of whether such services are performed or ordered by a Provider and regardless of where the services are performed.

Day Treatment Program. Mental health or Substance Abuse services on an individual or group basis for more than two hours, but less than 24 hours a day, in a Hospital, mental health center, Substance Abuse Treatment Facility, or Community Mental Health Center.

Deductible. If your Plan has a Deductible requirement, the Deductible is the amount you are required to pay for Covered Services each Calendar Year before the Plan begins to pay Benefits.

Dental Service. Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

Dependent. A member of the Subscriber's family who meets the eligibility requirements to be a Dependent under this Agreement.

Designee. Someone who is 18 years of age or older whom you designate to act on your behalf.

Diagnostic Service. A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Domiciliary Care. Services (including therapeutic services) and room and board provided in a hotel, health resort, home for the aged, residential facility, treatment center, halfway house, or educational institution because a Member's own living arrangements are inadequate or unavailable.

Durable Medical Equipment. Equipment that meets all of the following criteria:

1. Can withstand repeated use;
2. Is used only to serve a medical purpose;
3. Is appropriate for use in the patient's home;
4. Is not useful in the absence of illness, injury or disease; and
5. Is prescribed by a Physician.

Durable Medical Equipment does not include fixtures installed in your home or installed on your property.

Early Intervention Services. Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Experimental or Investigational. Procedures, treatments, services, equipment, supplies, devices, drugs, medications, and biologics that MCHO determines to be experimental or investigational for the purposes of diagnosis or treatment of an illness or injury. MCHO makes these determinations based upon criteria adopted by MCHO. The following are examples of Experimental or Investigational items:

1. Drugs classified by the FDA as treatment investigational new drugs;
2. Services involved in clinical trials;
3. Devices that have an FDA investigational device exemption; and
4. Devices for which the FDA has limited access or approval.

Freestanding Imaging Center. An institution that is licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center.

Health Insurance Marketplace. The Health Insurance Marketplace (formerly known as an "Exchange") is a mechanism intended to provide a transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans.

Hearing Aid. A non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including but not limited to frequency modulation systems.

Home Health Agency. An institution that is licensed as a home health agency.

Hospice. A facility or agency that is licensed to provide Hospice Care.

Hospice Care. Services provided on a 24-hours-a-day, 7-days-a-week basis to a person who is terminally ill and that person's family. Hospice Care includes, but is not limited to, Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and Durable Medical Equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

Hospital. An institution that is duly licensed by the State of Maine as an acute care, rehabilitation, or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Errors of Metabolism. A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Infertility. Infertility means either of the following:

1. Being unable to conceive despite engaging in frequent sexual relations without contraception for a year or more; or

2. Having a condition that is a cause of infertility recognized by the American Congress of Obstetricians and Gynecologists , the American Urological Association, or another appropriate independent medical society.

In-Home Biometric Monitoring. The delivery of in-home monitoring devices that help patients take a more active role in their health. It allows clinicians to remotely monitor patients in their homes and enables secure, two-way flow of information between remote caregivers and patients.

Inpatient. A Member admitted to a Hospital, Skilled Nursing Facility, or residential treatment facility for an overnight stay in a bed. "Inpatient" excludes a patient who is kept overnight in a Hospital solely for observation, regardless of whether the patient occupies a bed.

Inpatient Stay. A period of uninterrupted Inpatient confinement that begins with formal admission and ends upon discharge. An Inpatient Stay may include a Medically Necessary transfer from one Hospital to another Hospital as an Inpatient.

Maintenance Medications. A prescription drug that is prescribed to you by your Provider for treatment of a long-term condition or illness (e.g., blood pressure medication, cholesterol medication). Medications that are prescribed to treat short-term conditions (e.g., antibiotics) are not considered Maintenance Medications.

Maintenance Therapy. Any service, procedure, treatment, or therapy that preserves the present level of function and prevents deterioration of that function. Maintenance Therapy occurs when the condition of the patient receiving the service, procedure, treatment, or therapy does not or is not expected to improve, or when the goals of a treatment plan have been met.

Maximum Allowable Charge or Maximum Allowance. The maximum amount that a Member and MCHO will pay a Plan Provider for a Covered Service. The Maximum Allowable Charge or Maximum Allowance equals the Usual, Customary, and Reasonable Charge for a Covered Service.

Medicaid. A state medical assistance program under Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, known as "MaineCare" in the State of Maine.

Medical Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. For pregnant women, having contractions and there is inadequate time for a transfer to another Hospital or if there is a safety issue involved.

Medical Necessity or Medically Necessary. Health care services or products provided to a Member for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1. Consistent with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site, and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of best practices in the medical profession; and
5. Not primarily for the convenience of the Member or Provider.

Medicare. The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member. Any person, including Dependents, covered by this Agreement.

Non-Plan Providers. Health care Providers that do not have a written agreement with MCHO to provide health care services under this Agreement. Providers who have not contracted or affiliated with our specified subcontractor(s) for the services they perform under this plan are also considered Non-Plan Providers.

Obesity. A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Open Enrollment. The timeframes described in section 3.A.1 where individuals may first enroll for coverage under the Plan. These are also the timeframes when current Members may change plans offered by MCHO.

Orthognathic Surgery. A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device. A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Out-of-Pocket Cost. The portion of the cost of services for which the Member is personally responsible. Out-of-Pocket Costs include Copayments, Coinsurance, and Deductibles.

Outpatient. A patient, not an Inpatient or Day Treatment Program participant, who obtains services at a facility of a Provider. Outpatient includes an overnight observation in a Hospital, even if the patient uses a bed.

Physician. A licensed medical doctor (MD) or doctor of osteopathic medicine (DO).

Placed for Adoption or Placement for Adoption. The assumption and retention of a legal obligation for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered Placed for Adoption.

Plan Provider. Licensed or certified Providers who are under contract with MCHO to provide care to the Plan Members. Plan Providers are listed in the Provider Directory.

Premium. The periodic fee required for coverage of Members as provided in this Agreement.

Primary Care Provider ("PCP"). A Physician specialist in internal medicine, family practice, general practice, pediatrics, or obstetrics and gynecology, or a certified nurse practitioner or certified nurse midwife licensed by the Maine Board of Nursing, who is under contract with MCHO to provide and authorize Members' care.

Prior Approval. The system by which a Member must first have approval from MCHO before receiving Covered Services.

Protected Health Information (PHI). Any information, protected by HIPAA, about an individual's health condition or status, health care, or payment for health care that can be linked to such individual.

Provider. A licensed health care institution, facility, or agency or an independently billing, licensed, or certified health care professional acting within the scope of his or her license or certification. Providers also include (i) health care institutions, facilities, agencies, and professionals that have written participating agreements with us (Plan Providers), and (ii) other health care institutions, facilities, agencies, and professionals as required by law.

Provider Directory. A list of Plan Providers, including PCPs and Specialists. The Provider Directory may be updated without prior notice.

Radiation Therapy. The use of high energy penetrating rays to treat an illness or disease.

Referral. The recommendation of a Provider (usually the PCP) for a Member to receive Covered Services from another Provider.

Rider. A written attachment to this Agreement purchased by or on behalf of a Member that provides for additional, different, or reduced Covered Services, or another document that otherwise modifies the terms of this Agreement. In the event of a conflict between the terms and conditions of this Agreement and the terms and conditions of a Rider, the terms and conditions of a Rider shall rule.

Rural Health Center. An institution that is certified by the U.S. Department of Health and Human Services under the United States Rural Health Clinic Services Act.

Skilled Nursing Facility (SNF). An institution that meets all of the following requirements:

1. Licensed as a Skilled Nursing Facility;
2. Approved for payment of Medicare benefits, or otherwise qualified to receive approval for payment of Medicare benefits;
3. Primarily engaged in providing, in addition to room and board, skilled nursing care under the supervision of a duly licensed Physician;
4. Provides continuous 24-hours-a-day nursing service by or under the supervision of a registered nurse; and
5. Maintains a daily record for each patient.

Special Enrollment. Enrollment of a Member or Dependent under the Plan as allowed under section 3.A.2. Special Enrollment is allowed after certain events happen.

Specialist. A Provider who practices in a specialty area of medicine, including, but not limited to, radiology, cardiology, surgery, orthopedics, and oncology.

Subscriber. The person who meets the eligibility requirements to be a Member as described in this Agreement and who is not a Dependent. For a person to qualify as a Subscriber, we must have received and approved the required [*Single Streamlined Application*] and Premium.

Substance Abuse Treatment Facility. A residential or nonresidential institution that meets all of the following requirements:

1. Licensed or certified as a Substance Abuse Treatment Facility;
2. Provides care to one or more patients for alcoholism and/or drug dependency; and

Is a freestanding unit or a designated unit of another licensed health care facility.

Urgent Care. Medical care or treatment with respect to which the application of the time periods for making non-urgent Prior Approval decisions could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or, in the opinion of an attending Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This does not include Medical Emergency services. Urgent Care does not include medical care or treatment with respect to a Medical Emergency.

Usual, Customary, and Reasonable Charge. As determined by MCHO, an amount that is consistent with a usual range of charges by Providers for the same, or similar, services, equipment, or supplies in the geographic area where the service, equipment, or supply was provided to a Member.

Utilization Review. The process MCHO uses to determine the Medical Necessity, appropriateness, effectiveness, or efficiency of health care services. Techniques include Inpatient admission review, continued Inpatient Stay review, discharge planning, post-admission review, and case management.